# Annual Report and Annual Accounts 2015-2016

**NHS South Sefton Clinical Commissioning Group**

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# Performance report

## Overview of our year

Welcome to our third Annual Report and Accounts. It sets out our progress and achievements over the past 12 months, as well as the challenges we face in the year ahead.

We hope you find it both a useful and interesting account of our work.

You will read about some of our most important strategies and programmes – like Shaping Sefton, which looks to better join up all health and social care services, so they are more responsive, sustainable and effective for the benefit of our patients.

You will also find out about how well the services we commission performed during the year and what we are doing to further improve this. We made good progress amidst ever tightening financial constraints across the NHS, and whilst we are pleased with this, we know there is more to do.

Now in our third year, our work and our relationships with some of our most important partners are maturing. This has gained us national recognition in a number of areas including for our Care Home Innovation Programme, medicines management schemes, cancer leadership and workforce initiatives.

Importantly, we have been looking at how we can strengthen our work with our local communities to ensure services are the best they can be, and we would like to thank all those who have shared their views and experiences over the past year. We have learned a great deal, and later in the report you will find examples of where we are using people's feedback to inform how we develop future healthcare.

We pay thanks to those outgoing members of the Governing Body who have contributed to our progress during 2015-2016 – whose skills and experience will be greatly missed - and we look forward to welcoming some new faces from 1 April 2016 following elections amongst our GP practice membership and recruitment of a new lay member.

We know there are great challenges ahead for the NHS and we will continue to work hard to meet our duties over the coming 12 months towards improving health and wellbeing of local people.

**Dr Craig Gillespie**

**Chair**

**Fiona Taylor**

**Chief officer**

# About us

We are NHS South Sefton Clinical Commissioning Group (CCG) and we are responsible for planning and buying – or 'commissioning' – nearly all local health services for our residents.

The Health and Social Care Act sets out our full statutory duties. This came into effect on 1 April 2013, when we formally became responsible for local healthcare commissioning.

Made up of doctors, nurses, lay representatives and other health professionals, we are a membership organisation bringing together all 31 doctor's surgeries in south Sefton. A legal 'constitution' sets out how our member practices work together as part of our CCG.

We have a small Governing Body of elected GPs, practice staff, lay representatives and other professionals who accountable for our organisation and who make decisions about our work on behalf of the wider membership.

We support practices to be actively involved in the work of the CCG. Much of this work is carried out in 'localities', covering four geographical areas, so practices can really focus on addressing the health needs of their individual communities.

Our four localities are Bootle, Crosby, Maghull, Seaforth and Litherland

Collectively, the range of services we are responsible for includes:

- Community based services – like district nursing and blood testing
- Hospital care – including routine operations, outpatient clinics, maternity services and accident and emergency care
- GP out of hours services – to ensure people still have access to a doctor when their surgery is closed in the evenings, weekends and bank holidays
- Mental health services – we commission many mental health services apart from very specialised care and treatment

We do not work alone. By joining together with a wide range of partners to commission services we aim to achieve more for our residents. This is particularly important in this financially challenging time for all public sector organisations, so we look to pool our resources and coordinate our efforts whenever we can.

Our residents also play an important role in helping us to shape our plans and we involve them in our work in a number of different ways – from routinely gaining their views and experiences, to inviting representatives to join some of our most important groups and committees.

You will read more about these different aspects of our work throughout this report and you will also find a range of further information on our website www.southseftonccg.nhs.uk

# What we do

We work with the local community and other partners, to improve the health and healthcare of everyone living in south Sefton, spending money wisely and supporting clinicians to do the best job they can.

In 2015-2016 we had a budget of £239 million to spend on commissioning health services for 154,745[1] south Sefton residents. We met all our financial duties during the year and you can see a breakdown of how we spent the money allocated to us for local health services on page 34.

The majority of our budget, around 65%, is spent on hospital based services. Whilst we support people's right to choose where they are treated and who provides their care[2], the majority of the services we commissioned in 2015-2016 were from Aintree University Hospital NHS Foundation Trust and Liverpool Community Health NHS Trust.

Our other main service providers include:

- Mersey Care NHS Trust – the leading mental health trust across Merseyside
- North West Ambulance Service NHS Trust –providers of patient transport services as well as its network of emergency response vehicles
- Midlands and Lancashire Commissioning Support Unit – which provides many of our administrative and operational functions like procurement and performance reporting
- Other NHS organisations – like Southport and Ormskirk Hospital NHS Trust, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool Women's NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust and Liverpool Heart and Chest Hospital
- Community and voluntary sector organisations – like Sefton Carers Centre and the Alzheimer's Society
- Independent and private sector providers – including Go To Doc that is led by doctors and provides our GP out of hours service

So we can make the right commissioning decisions for our patients' needs, we continually review and monitor local services to make sure they meet the standards and quality we expect. Alongside this, we routinely assess all the information and medical evidence we have about current health and health services in south Sefton, to inform what more we need to do. Our plans also have to meet a number of nationally set standards and requirements like the NHS Outcomes Framework[3], the Five Year Forward View[4] Assurance Framework for CCGs[5] and the NHS Constitution[6], which also sets out the legal rights of our patients' and staff and what is expected from them in return – so we can all get the best from the NHS and the resources it has at its disposal.

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[1] 2015-2016 estimated GP weighted population for south Sefton
[2] Choice of place of treatment is one of the rights included in the NHS Constitution
[3] NHS Outcomes Framework - http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/
[4] Five Year Forward View - http://www.england.nhs.uk/ourwork/futurenhs/
[5] Assurance Framework - https://www.england.nhs.uk/commissioning/ccg-auth/
[6] NHS Constitution - http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

# Who we work with

There are a number of other organisations that are involved in planning, buying, providing or overseeing your health and social care services, and we work closely with them all.

### NHS England

Together with NHS England, we work to ensure health services for south Sefton residents meet national and local standards. Whilst we are responsible for improving quality in primary care, NHS England is the commissioner of these services. This was the first year that we had 'greater involvement in primary care co-commissioning' through NHS England's new arrangements giving CCGs more say about the future of these services. This arrangement is helping us to develop primary care in line with our vision for all future healthcare through our system wide Shaping Sefton programme. Locally, the Cheshire and Merseyside Area Team oversees standards and holds the contracts for GP surgeries, dentists, pharmacists and opticians, as well as some screening and immunisation programmes. Other local teams commission some additional services you may need, including specialist, prison and armed forces healthcare.

### Sefton Health and Wellbeing Board

We are core members of Sefton Health and Wellbeing Board. This committee of Sefton Council brings us together with others who have a lead responsibility for health and social care in the borough, including local councillors, council officers, NHS providers and Healthwatch Sefton. Together, we have devised a Sefton wide strategy for health and social care services. This was based on our Joint Strategic Needs Assessment, which brings together all the information we have about current services, to highlight where we need to do more in the future.

### Sefton Council

The local authority is responsible for promoting and protecting good health across Sefton. It works closely with the national body, Public Health England to do this in partnership with NHS England and ourselves. Our joint aim is to encourage people to live longer, healthier lives, and to reduce the variation in levels of health experienced in different parts of Sefton. Much of this work is now coordinated through the Health and Wellbeing Board. In addition to this, we are working with Sefton Council to decide how best to spend the portion of existing NHS money being set aside for the new Better Care Fund. The aim of this is to support more seamless health and social care services that work better for patients, and we know we have more work to do to achieve our vision and meet our shared targets. We also share some joint commissioning posts with the local authority including those for some aspects of mental health and children's services.

### Other clinical commissioning groups

We work with neighbouring clinical commissioning groups to plan and buy services when there is a benefit for south Sefton residents, or where services are provided across a wider geographical area, like hospital care. We share a small management team with neighbouring NHS Southport and Formby CCG as well as employing staff dedicated solely to our work.

This means we are able to maintain efficient running costs and share good practice where it offers benefits to our local residents. It also helps us to work more effectively with Sefton Council and the Health and Wellbeing Board on borough wide programmes and initiatives. This is particularly important when we are addressing the variations in health that exist in different parts of Sefton, so that no one community is disadvantaged and improvements are experienced by all.

### Provider organisations

The majority of services we commission are from other NHS organisations like hospital and community services trusts. In addition, we also commission some services from the voluntary, community and faith sector and private providers. We closely monitor the work of all our providers to ensure their services meet the high standards of quality we expect for our patients. We also involve our providers in planning how we might improve care in the future, and a number of these organisations are represented on some of our most important working groups.

### Healthwatch Sefton

This independent organisation works on your behalf to ensure health and social care services are safe, effective and right for you. Healthwatch Sefton gathers and represents the views of people living in the borough. Due to its independence, Healthwatch can challenge those who provide services but it can also work in partnership with us and other statutory bodies to improve frontline health and social care. The chair of Healthwatch Sefton is a co-opted member of our Governing Body. The organisation also has representation on some of our other committees and working groups, including our Engagement and Patient Experience Group.

# About south Sefton

There are a number of distinct environmental and social factors that we must take account of when we are planning health services for south Sefton – an area stretching from Bootle in the south, Hightown in the north and Melling and Lydiate in the east – including:

- Our population is made up of a significantly higher proportion of older residents with an estimated 19.3% (approximately 29,900) of the population over the age of 65, compared to 17.5% aged over 65 nationally. This is expected to grow to more than 35,000 in the next ten years
- Whilst our residents aged 85 years and over is smaller in number than other age groups, we expect this to rise significantly from an estimated 4,000 in 2015 to an estimated 4,500 by 2019 - an increase of almost 14%
- South Sefton has significantly higher levels of deprivation and child poverty with almost 32% of the population are considered to live in the most deprived 10% of neighbourhoods in the country

Overall, health in south Sefton is getting better, but there are clear areas for improvement:

- Within our most deprived communities, average life expectancy is 11 years less than people living in the more affluent parts of the area
- Levels of long term health conditions are much higher than the national average - particularly heart disease, respiratory disease, kidney disease, mental health conditions and obesity

Levels of early deaths from heart disease have reduced over the last decade as smoking rates have reduced and our patients are better educated about risks to their health and the importance of leading a healthy lifestyle but we know there is still more to do to improve this.

Our work through Sefton Health and Wellbeing Board is central to this and during 2016-2017 we will look at how we can further strengthen joint working arrangements through a new post focusing on prevention and early intervention.

# Shaping Sefton

We want all health and care services to work better together – to be more joined up – with as many as possible provided in our local communities, so it is easier for you to get the right support and treatment first time, to help you live a healthy life and improve your wellbeing.

We call this vision **community centred health and care** – where services are wrapped around our patients and our GP practice localities, with hospitals concentrating on specialist care for our most poorly patients.

We are working towards this vision through our Shaping Sefton programme.

Demand for healthcare has never been so great and our patients' conditions are becoming more and more complex. This comes at a time when resources across the NHS, like other public bodies, are challenged. So, we believe that all partners involved in providing health and social care need to work more effectively together, so we can continue to provide quality services into the future.

In addition, we believe this approach will also help us to more effectively address the biggest issues that affect our residents' health, which are often linked to wider social issues like their lifestyle, or the area of south Sefton that they live in (page 8).

Shaping Sefton looks right across health and care organisations in the borough to determine how they might work better together as a more united system. Whilst we are leading this programme, we are working closely with Sefton Health and Wellbeing Board on this work.

Underpinning Shaping Sefton is our 5 year strategy and our blueprint for transforming healthcare, which we have developed jointly with our partners from NHS Southport and Formby CCG.

**Community centred health and care** brings together eight priority health and transformational programmes, wrapped around our GP practices and their patients:

**care for older and more frail people | primary care | community services | urgent care | mental health | cardiovascular disease | respiratory disease | intermediate care**

Our Shaping Sefton programme will be further developed in 2016-2017, through the development of a new Sustainability and Transformation Plan (STP)[7] – which will see us working more formally with CCGs and the various NHS organisations that provide services on our behalf, right across Cheshire and Merseyside. STPs set out a new approach in the NHS to ensure that services are planned by place rather than around individual organisations and institutions. Whilst our STP will set out how we will work collectively across the region on those services that affect all our patients, here in south Sefton we will still produce a local operational plan each year, which focuses on those aspects of healthcare that really affect our residents.

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[7] Sustainability and Transformation Planning - https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

# What this means for you

In addition to those core services that we routinely commission, we have developed a number of schemes and programmes towards our vision for community centred health and care. These really focus on the specific health needs of our residents.

Here are some examples of our work across our ‘blueprint’ priority areas in 2015-2016:

## Care for older and more frail people

### CHIP – our care home innovation programme

This is the second year of our CHIP programme – one of the first schemes of its kind to offer care homes and their residents such a comprehensive package of support. There are several elements to CHIP including a telemedicine scheme, allowing care home staff to access medical advice and support using a secure video link. The CHIP team also includes a community geriatrician, pharmacist, speech therapist, dietician and community psychiatric nurse. CHIP aims to reduce care home residents being sent into hospital unnecessarily, and we are beginning to see some positive results for these patients in improving their quality of their lives. We have funded six new dedicated care home matron posts this year to join the CHIP team, which will complement the telemedicine service. In addition to extra medical support, CHIP brings care home staff together for regular monthly meetings, providing a range of training and support to help staff better care for their residents.

### Preventing the harm caused by falls

We have funded a new falls coordinator post to work alongside our community geriatrician in Litherland Town Hall, providing prevention and care to those residents at greatest risk of harm from falling. In the year ahead, this new post will also link closely with our community based urgent care team and occupational therapists. We have also commissioned a three year falls officer post within the council’s Active Sefton team to provide bespoke falls prevention exercises and education to residents in care homes, residential homes, sheltered accommodation and older peoples’ clubs in south Sefton. Alongside this we are leading work across the wider health and social care system to improve the pathway of care for our patients.

### Care home medicines project

For the third year in a row we offered annual medication reviews to care home residents. Through more regular monitoring of patients’ medicines we can ensure they are taking the most appropriate ones for their condition at the right time. In 2015-2016 we reviewed more than 250 patients, the scheme helped prevent people from needing hospital treatment over 30 occasions. In excess of £14,500 was also saved through better and more effective prescribing. In addition, pharmacists also provide advice to nursing home staff around the safe management of medicines, and act as a bridge between nursing homes, primary care and hospitals – all with the aim of improving the treatment and experience for this vulnerable group of patients.

### Acute frailty unit

Many of our older patients who are taken to hospital for an urgent health problem often have to wait a long time before seeing the specialist medical staff who can support them back home, where they will often make a better recovery. To address this, Aintree Hospital has set up an acute frailty unit to move these patients more quickly from A&E and into a more dedicated care setting. The unit has a much broader array of staff than a usual ward. This means patients are able to be assessed, stabilised and move back home much quicker with reablement support. Building on this approach, we are working with Liverpool CCG and Knowsley CCG to commission a common integrated frailty pathway that incorporates community, hospital and social care from home to hospital and home again.

## Primary care

### Quality in primary care

Whilst we do not hold the contracts for GP practices, which is the responsibility of our partners at NHS England, we are committed to improving the quality of primary care. To do this, we have further developed our local quality contract, which our member practices can choose to sign up to. There are a number of schemes that make up the contract, including one to increase access. During 2015-2016 this resulted in an additional 128 appointments per week being made available to patients.

### Locality schemes

During the year we extended a number of schemes across all our GP practice localities after they each showed success during their initial pilots. This included our award winning stoma care project and inhaler technique reviews – developed by our Bootle locality – and health checks for housebound patients – devised in Crosby. Patients across south Sefton will now benefiting from their introduction.

### Healthcare assistant apprenticeship scheme

Our first healthcare assistant apprentices graduated in February 2016 from a course developed by our quality team in partnership with Hugh Baird College. We devised the exciting 15 month apprenticeship in response to the Francis Report, to support workforce development in primary care. Introduced in November 2014 practices received part funding to train and develop an apprentice healthcare assistant. All 10 apprentices across Sefton completed their training with an advanced diploma in health and social care. All have been given permanent employment within practices and three have been accepted for nursing degree courses at local universities. The course is being evaluated by Edge Hill University.

### General practice nurse foundation

In 2015, two nurses completed the general practice nurse foundation course commissioned by Health Education North West and provided by Liverpool John Moores University. These nurses secured permanent practice based posts within Sefton. We promote this course as a foundation for new to practice nurses to gain insight into the role and assist with their development as general practice nurses. Our quality team actively contributes to the training programme and have helped to develop the course content.

### Making Every Contact Count

Practice staff are generally the first point of contact for anyone wanting help for a health problem. Across south Sefton these staff speak with hundreds of people every day. Our Bootle locality is harnessing the potential of its reception staff to 'Make Every Contact Count' (MECC) in helping people to make healthier lifestyle choices. Administration and reception staff from all seven practices in the locality have received MECC training, so they can carry out opportunistic health chats with patients about ways to improve their lifestyles. We have also begun to extend the training to other localities and early feedback from staff has been very positive.

## Community services

### Reviewing current provision

Community services is the collective name for a range of care and treatments that are often provided from health centres, clinics and sometimes in patients own homes. They include blood testing, care for leg ulcers and feet, community matrons and health visitors. We have been working closely with our GP membership to review our community services during the year in line with our vision for community centred health and care. Better understanding what patients think of these services is an important part of our review. So we have also been asking our residents about their experience of community services and their views are informing our work.

### Virtual Ward – proactive care

Our proactive care programme is aimed at those with long term conditions, particularly older patients, helping them to stay as well as possible, for as long as possible through a package of preventative care provided in their own home, or close to their home. They are offered proactive 12 week intensive support to improve their health and wellbeing. Now in its third year, the programme focuses on patients who are at most risk of being admitted to hospital and works to prevent the health of these patients from deteriorating, which can otherwise result in them needing urgent or emergency care. Doctors identify patients who will benefit from pro-active care and refer them to their locality pro-active care team. There are four teams, one for each of our GP practice localities. The teams bring together a wide range of health and social care professionals to coordinate and tailor support based on each patient's individual needs – this could be medical treatment provided by a nursing team, or help and advice about improving their lifestyle from a community health and wellbeing trainer, who works with patients and carers to access services such as befriending, reablement, community activities, welfare rights and social services. In 2015-2016, 1,800 people were referred by their GP to the programme for care and support.

### Litherland Walk in Centre

We have increased the number of nursing staff in Litherland Walk in Centre to improve patients' experience of the care provided at the Hatton Hill Road service.

# Urgent care

## Community urgent care team

Now in its second year, this team provides a rapid response to patients who need urgent healthcare but who do not need to go to hospital. For patients, this means more appropriate care, often in their own home. Being admitted to hospital can be distressing for some patients and may also not provide people with the most effective care for their condition. So, the team works alongside community intermediate care to continue to monitor and manage patients in their own home whenever possible. The urgent care team also works closely with GP practices, ambulance crews, hospitals, the pro active Virtual Ward team and other community based service to identify, care and monitor patients. During 2016-2017 we plan to widen the scope of the team to include chronic obstructive pulmonary disease (COPD), intravenous cellulitis treatments, heart failure deterioration and specialist palliative care, so it provides more comprehensive care.

## Identifying the right care for A&E patients

We are working closely with our community services provider to ensure that there is a permanent member of staff based at Aintree Hospital's A&E department. This will help to ensure that patients coming into the emergency department get the most appropriate care for their needs. Those who need support but do not need to be admitted to A&E will be seen by community nursing staff, which will help to ensure they can return home more quickly, linking closely with Social Services if a patient needs extra help.

## Acute Visiting Scheme and Alternative to Transfer

These schemes were launch in January 2015 and due to their success, we decided to run them for a further 12 months. Both are managed by our out of hours provider Go To Doc, working together with the North West Ambulance Service (NWAS). In normal working hours, GP practices can refer their acutely unwell care home patients to the Acute Visiting Scheme (AVS) who will carry out a home visit, reducing the risk of patients being admitted to hospital and increasing the capacity of GP practices. The alternative to transfer (ATT) service operates 24 hour a day, seeing Go To Doc working with NWAS to divert patients to more appropriate care instead of A&E whenever possible – this could be the community urgent care team, or by carrying out a home visit. The programmes diverted 569 patients away from A&E in the year. It is estimated that the schemes prevented 290 people from being admitted to hospital with over 2,000 bed days avoided. In addition, there were 694 care home visits during the same period. This is greatly beneficial for our most frail patients and at the same time helped to reduce pressure in general practices at this busy time for primary care.

# Mental health

### Improving psychological therapies

We had a new provider for our Improving Access to Psychological Therapies service, known as IAPT, from April 2015 following a re-procurement process. Called Access Sefton, the service gives people across the borough greater access to a wider range of psychological therapies. Residents can now contact the service directly, rather than being referred to Access Sefton by their GP if they prefer. We recognise the links that exist between physical and mental health conditions. So, Access Sefton is connecting with a range of local health professionals so that people with long term conditions can be offered help as part of their overall care.

### Diagnosing dementia

This is a national priority and we are working with our member GP practices and service providers to improve dementia diagnosis rates in a number of different ways. This includes carrying out dementia screening with patients who are part of our Virtual Ward proactive care programme and CHIP, our care home innovation programme. We expect all these initiatives to help us to increase dementia diagnosis rates in the year ahead.

### Child and adolescent mental health

We have developed a Sefton wide transformation plan for children and young people's mental health and wellbeing for 2015-2020. It follows the national taskforce report 'Future in Mind' and our commitment to use £209,000 exclusively on transforming local mental health services for children and young people. In the year ahead we will use £73,000 of this funding to establish a new specialist community eating disorder service for 0-18 year olds.

### Early intervention psychosis

Since July 2015 we have been working closely with Mersey Care NHS Trust to identify the additional resources we need to meet the new early intervention psychosis two week waiting time standard -which comes into place from April 2016 - and the service being offered to those people aged 35 and above. We plan to invest additional resource in the year ahead. Early intervention services provided by dedicated teams are highly effective in improving peoples' outcomes and reducing future demand on mental health services.

### Modernising mental health facilities

Working with neighbouring CCGs and Mersey Care NHS Trust we have seen investment in the new generation purpose built Clock View mental health inpatient facility. Clock View is designed improve the experience of patients by providing a therapeutic environment combined with patient centred care to improve recovery, wellbeing and reduce lengths of stay. It offers individual bedrooms, all with en-suite bathrooms, across five wards. Clock View has safe access to inner courtyard gardens, along with many other dining, meeting, leisure, clinical, activity and quiet areas for patients, staff and visitors.

# Cardiovascular disease

### Diabetes

We have been successful in enrolling in the first wave of the new national diabetes prevention programme. The aim of the scheme is to prevent those at risk of type 2 diabetes from developing the condition. Type 2 diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack and stroke. As well as the human cost, type 2 diabetes treatment currently accounts for just under nine per cent of the annual NHS budget. Nationally, this equates to around £8.8 billion each year. We know from evidence schemes that support people to maintain a healthy weight and be more active can significantly reduce the risk of developing the condition. The NHS diabetes programme will be launched locally in the year ahead. Those referred will get tailored, personalised help to reduce their risk of type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

### Stroke care

With Cheshire and Mersey Strategic Network, we are working to improve the quality of stroke services across the borough. This is also seeing us working together with Liverpool and West Lancashire CCGs and our providers to ensure that stroke services are equitable and better meet the needs of our residents. This work, particularly around the management of hyper acute stroke, will help us to meet performance targets related to stroke (page 21).

### Preventing stroke

In partnership with Cheshire and Mersey Strategic Network, we have been central in developing a clinical pathway for people with, or at risk of, atrial fibrillation - a condition which is known to increase the risk of stroke. This is based on a number of fundamental principles including prevention, early detection and improved treatment of atrial fibrillation.

### Stroke rehabilitation and life after stroke

Stroke supported discharge teams provide an early, intensive rehabilitation service for patients. Our aim is to help patients leave hospital more quickly and return to their own homes, so that they can maximise independence and improve quality of life following a stroke.

### Acute kidney injury

Again, working with the Cheshire and Mersey Strategic Network Acute Kidney injury group, we are looking at ways we can reduce avoidable harm and death for people with acute kidney injury, and to improve care for patients when in hospital. We want there to be more care before people require emergency treatment by moving services towards patients at home and in primary care. This work will develop in the year ahead.

# Respiratory disease

### Inhaler technique project

Originally, this project was developed by our Bootle locality in response to the high numbers of respiratory patients regularly being admitted to hospital as a result of their condition worsening. The scheme is now being rolled out to our three other localities – Crosby, Maghull and Seaforth and Litherland. Practices identify their patients who would benefit from an inhaler review. A trained pharmacist then carries out one to one sessions with patients, also offering them advice and referral to smoking cessation, pulmonary rehabilitation and further lung tests where necessary. Nearly all of those who were then trained in correct techniques showed vast improvements during a follow up assessment, improving the self management of their condition.

### Self management course

Our ‘Breathe Well’ course was developed as a direct result of what patients and carers told us would make a difference to their lives. We worked closely with a patient representative to design the course and the first six week programme took place in early 2015, led by Sefton CVS on our behalf. Sessions offer practical advice and support, including psychological therapies to help them cope and manage their conditions positively and pulmonary rehabilitation.

### Capturing unidentified need

During 2015-2016 the ‘Breathe Well Bus’ was out and about in south Sefton offering passers by a free lung health check. Over the winter months we know that breathing conditions are worsened by the colder weather. So, the respiratory team took to the streets to give people advice about looking after their lungs and to spot any problems they may have, no matter how small, as early as possible. This has helped to identify people who did not know they were living with a breathing illness, and in turn signpost them for treatment and support to improve their condition.

### Respiratory training programmes

We developed a comprehensive training programme that was launched this year to better support practices across our four localities to better manage their patients with chronic obstructive pulmonary disease (COPD) and asthma.

### Supporting those at greatest risk from breathing illnesses

The scheme was initially focused on three practices, reviewing 50 of their patients who were admitted to hospital due to their breathing conditions. Intensive support was given to practice nurses, healthcare assistants and doctors. Due to its success, we are rolling out the programme to all our localities in 2016-2017.

## Intermediate care

### Improving these services

This is sometimes called a ‘halfway home’ service for people who do not need hospital care but who need some additional support to help them recover fully from illness or injury. Intermediate care brings together a range of services to promote faster recovery from illness, prevent unnecessary urgent admission to hospital, premature admission to long term residential care, or to support timely discharge from hospital – all with the aim of maximising people’s independent living. In 2015-2016, we worked closely with Sefton Council to improve intermediate care through our Better Care Fund programme. During 2014-2015 we reviewed current services and began work to draft a blueprint for how these might be improved in the year ahead. We want future services to give increased focus on ‘step up’ care, for those people who may not have been admitted to hospital but who need additional support for their condition. We expect future intermediate care to be largely provided in a person’s own home but these services will need to be flexible so that some people with additional needs can be treated in a community based intermediate care setting when they need it.

## Other examples of our work

### Improving care for cancer patients

We are working together with neighbouring CCGs, our providers and other partners around a range of initiatives to improve cancer care and recovery. This includes work to improve patient pathways specifically for brain and ovarian cancers. With Cancer Research UK and Macmillan we are looking at how we can support earlier cancer diagnosis and improve outcomes for our patients. As more patients are successfully treated for their cancer we need to support them to better live with and beyond cancer. We have secured a Macmillan funded post in south Sefton to look at what we can do to ensure our patients have better access to community based services and support in the future.

### Award for cancer lead

Our cancer and end of life lead, Dr Debbie Harvey, won a national award for her work across primary and secondary care. Debbie received the inaugural ‘David Millar award’, named after Macmillan’s original GP adviser at an annual Macmillan conference in London. Macmillan regional GP advisers were invited to nominate worthy recipients to be considered for the award. Dr Hong Tseung nominated Debbie for her achievements within the primary care community, working across boundaries.

### Children’s services

We continue to want an integrated community model of care for children and young people, underpinned by community nursing, support and therapies. We also want enhanced palliative care and psychological services for children and young people, as well as services that are better equipped to deal with a child’s transition to adult care if needed. Our work to achieve this will continue in the year ahead.

### Education, health and care plans

This was the first full year of the implementation of the new Education, Health and Care Plans (EHCPs) introduced as part of the Children and Families Act (2014). We are required to contribute in a timely way to these plans, so that they can be issued within the new statutory 20 week timescale. We commissioned a team to carry out this work on our behalf. Working closely with Sefton Council we are meeting timescales for completing these plans.

### Care at the Chemist

This scheme gives more people easier access to free advice and treatment by simply visiting their local chemist, saving them a trip to their GP surgery. Anyone who joins Care at the Chemist can be assessed by an expert pharmacist, who will advise them about how to treat their condition. This includes supplying people with any medicines they might need, which are free for anyone who does not pay for prescriptions and costing no more than a prescription charge for everyone else. From speaking to people when we were developing our 5 year strategy, many told us they would like more services to be available at their local pharmacy and Care at the Chemist helps to achieve this.

### VCF fund

For the third consecutive year, and together with NHS Southport and Formby CCG, we invited voluntary, community and faith organisations to bid for a share of our £1 million non recurrent VCF Fund. We recognise the valuable role these groups play in achieving better health and wellbeing for our residents. This is reinforced by what local people consistently tell us, that these groups are important in providing them with support. Through Sefton CVS, organisations were asked to submit bids for one off funding to support specific initiatives. There were 37 successful bids in 2015-2016, specifically supporting the priority areas set out in our blueprint. These are exciting schemes, often designed and delivered by local people for others who live in their communities.

### Strand By Me

Liverpool football legend, Jamie Carragher, officially opened our new venture with voluntary, community and faith groups at the end of September 2015, aimed at supporting Sefton residents to better health and wellbeing. Strand By Me is a health and community shop being run by Sefton CVS and supported by the CCG. Each week there a different organisation sets out its stall at Strand By Me, from the Stroke Association to local NHS sexual health services. Residents can simply pop in to the shop, based on the lower floor of the Bootle's Strand Shopping Centre, to find out about a wide range of services and support available locally. The idea came from our locality GPs in Bootle and in its first five months over 3,000 people visited Strand By Me. To find out more about Strand By Me, as well as what's on and what's coming up, join the Facebook group at www.facebook.com/StrandByMeShop

## Only order what you need

This Sefton wide campaign ran for three months at the end of 2015 and encouraged residents to help save vital NHS resources by not over ordering repeat prescriptions. It is estimated that wasted medicines cost the CCGs around £2 million pounds per year, which could otherwise have been spent on frontline care. In addition, around half the population do not take their medicines as prescribed. So the campaign also highlighted the importance taking medicines as directed to ensure they are as effective as possible. Along with leaflets, posters and other materials, our medicine's management carried out a winter tour in supermarkets and community venues to spread the message. The campaign has gained ongoing local and national attention. This has led to our head of medicine's management being invited to share our good practice with other NHS partners at a conference in July 2016.

## Examine Your Options

This campaign uses striking and now well recognised imagery. It supports our wider work dealing with the additional demands on NHS services over the busy winter months, as well as encouraging patients' good use of health services year round. Examine your Options raises awareness of the range of healthcare available to residents when they are ill. It particularly focuses on pharmacy, GP out of hours and self care. This year, the campaign included newspaper advertisements promoting holiday opening times over Christmas, New Year and Easter. It could also be seen on the outside of buses, with posters inside targeting passengers. Supporting information materials were also distributed to a wide range of local organisations and at events.

## New ways to promote health information

We launched a new look website in March 2016, containing more health advice and information that is easier for people to access. We also joined Twitter, so we can signpost a much wider number of our residents to information about their health, wellbeing and local services. These new developments complement our existing Looking Local 'app' for smartphones and digital interactive TV information systems – all aimed at increasing access to health information for our residents.

# Our performance

To make sure we fulfil all our duties, our performance is regularly measured, monitored and scrutinised. This happens in a number of different ways - through our internal structures and processes as described elsewhere in this report, as well as being regularly assessed by NHS England.

There are also a number of documents that set out targets for different areas of our work. This includes the pledges contained in the NHS Constitution, the NHS Outcomes Framework, Assurance Framework for CCGs and the Better Care Fund.

In addition, we have also set ourselves some local quality measures in line with Everyone Counts – national guidance for CCGs on planning for patients. These have been determined by the needs of south Sefton residents and focus on where we need to make improvements in vey local and specific areas.

The work you have been reading about so far in this report has all contributed to our performance for 2015-2016.

Detailed information can be found in our integrated performance reports, which we now publish on our website in addition to being presented to our Governing Body at each of its public meetings[8].

## Performance in health

On the next pages you will see an overview of performance during the year. Nearly all of the measures shown are based on the performance of the organisations we commission services from. Where providers fall short of expectations, we work with them to support improvement and this sometimes includes contractual measures to ensure our services meet the best possible standards.

[8] All integrated performance reports and Governing Body papers can be found on our website www.southseftonccg.nhs.uk

The table below shows overall performance for start April 2015 – end March 2016

| NHS Constitution indicators | CCG | Main Provider |
|---|---|---|
| A&E 4 Hour Waits (All Types) | | Aintree |
| Ambulance Category A Calls (Red 1) | | NWAS |
| Cancer 2 Week GP Referral | | Aintree |
| RTT 18 Week Incomplete Pathway | | Aintree |
| **CCG Assurance Framework indicators and other key targets** | **CCG** | **Main Provider** |
| A&E 4 Hour Waits (Type 1) | | Aintree |
| Ambulance Category A Calls (Red 2) | | NWAS |
| Ambulance Category 19 transportation | | NWAS |
| Cancer 14 Day Breast Symptom | | Aintree |
| Cancer 31 Day First Treatment | | Aintree |
| Cancer 31 Day Subsequent - Drug | | Aintree |
| Cancer 31 Day Subsequent - Surgery | | Aintree |
| Cancer 31 Day Subsequent - Radiotherapy | | Aintree |
| Cancer 62 Day Standard | | Aintree |
| Cancer 62 Day Screening | | Aintree |
| Cancer 62 Day Consultant Upgrade | | Aintree |
| Diagnostic Test Waiting Time | | Aintree |
| Emergency Admissions Composite Indicator | | |
| Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) | | |
| Emergency Admissions for acute conditions that should not usually require a hospital admission | | |
| HCAI - C.Diff | | Aintree |
| HCAI - MRSA | | Aintree |
| IAPT Access - Roll Out | | |
| IAPT - Recovery Rate | | |
| Mental Health Measure - CPA | | |
| Mixed Sex Accommodation | | Aintree |
| Patient Experience of Primary Care i) GP Services ii) Out of Hours (Combined) | | |
| PROM: Elective procedures: Groin Hernia | | Aintree |
| PROM: Elective procedures: Hip Replacement | | Aintree |
| PROM: Elective procedures: Knee Replacement | | Aintree |
| PYLL Person (Annual Update) | | |
| RTT 18 Week Admitted Pathway | | Aintree |
| RTT 18 Week Non Admitted Pathway | | Aintree |
| RTT 18 Week Incomplete Pathway | | Aintree |
| RTT 52+ week waiters | | Aintree |
| Stroke 90% time on stroke unit | | Aintree |
| Stroke who experience TIA | | Aintree |
| Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s | | |
| Unplanned hospitalisation for chronic ambulatory care | | |
| Local Measure: Access to services BME | | |

| Better Care Fund performance | Sefton HWBB | Main Provider |
|---|---|---|
| Unplanned admissions to hospital (note Sefton Health and Wellbeing Board footprint, not CCG) | | |
| Rate of permanent admissions to residential care per 100,000 (Sefton Health and Wellbeing Board footprint) | | |
| Percentage of people still at home 91 days following hospital discharge | | |
| Local measure: dementia prevalence | | |
| Patient experience of primary care services where overall satisfaction was very good or good | | |

## Key

## Working to improve performance

- IAPT - Whilst we did not meet national access and recovery rates for IAPT in year, we did see an improving trend and we achieved the six and 18 weeks waiting time targets. Work with our new provider is helping us to make improvements towards meeting these targets

- Stroke - This year we just fell short of the national stroke target for patients spending 90% of their time on a stroke unit (80%). However we did achieve the 60% target for transient ischaemic attack (TIA)

# Monitoring and ensuring quality

Our Quality Committee is responsible for monitoring and overseeing performance against national requirements, such as those in the NHS Constitution[9], along with local quality standards including patient safety and patient experience, as well as health and safety. To do this, the committee receives and assesses a wide range of data and information from the organisations we commission services from, as well as from inside the CCG. We have developed a 'data dashboard' bringing together reports and information from the services we commission, so we can more easily take action, to promote safe and effective care from all providers. This work also reflects our commitment to ensuring we meet the recommendations contained in a number of important recent reviews such as Winterbourne and the Francis reports.

### Managing and responding to risks

Our Quality Committee provides the Governing Body with assurance that there are structures, systems and processes in place to identify and manage any significant risks that we may face. We continue to identify and manage risks through the corporate risk register which is presented to the Quality Committee ahead of the Governing Body. This helps us to ensure that local health services meet the highest possible standards of quality and patient safety. It also supports us in meeting our statutory duties as well as helping us to plan for a healthcare system which is robust and capable of dealing with unplanned events.

### Our quality strategy

Every patient and person that we support can and should expect high quality care. In 2015-16 the quality strategy underpinned how we commission services to ensure they are amongst the safest and most effective in the NHS. The strategy provided guidance on how services should be provided reliably to every patient, every time. There are six fundamental values at the core of our strategy - care, compassion, competence, communication, courage and commitment - known as the 6Cs. These six areas support us in commissioning excellent care and promoting enduring positive values and behaviours across the local NHS. Our strategy also reflects our commitment to working in partnership with local residents, engaging with people to make choices about their health and care to achieve 'no decision about me, without me'.

### Promoting and using research to improve care

We understand that commissioning the best possible care for our residents, means that we must also be an organisation that promotes research and innovation and uses research evidence in designing and planning services. We are also currently evaluating how serious incidents relating to pressure sores and healthcare associated infections (HCAIs) are investigated across our wider health system. We are an active partner in the Collaboration for Leadership in Applied Health Research and Care North West Coast. This research network has a specific focus on reducing the differences in health that exist across our diverse communities.

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[9] This brings together all the rights of our patients and staff http://www.england.nhs.uk/2013/03/26/nhs-constitution/

We continue to support our member GP practices who are keen to get involved in research within primary care and in meeting our research strategy for healthcare and preventive services.

## Improving Continuing Healthcare

During 2015-16 our quality team has had a continued focus on work to improve systems and the decision making processes for continuing healthcare (CHC) assessments. CHC is the name given to packages of ongoing care, which are arranged and funded solely by the NHS, and where patients aged over 18 have a 'primary health need', as a result of disability, accident or illness. We continue to ensure that appropriate health support is commissioned for our most vulnerable patients, underpinned by the specialist skills and knowledge to enable effective decision making about each patient's eligibility. We are now working with our commissioning support unit and we continue to work closely with Sefton Council where responsibility for an individual's needs crosses both health and social care.

### Personal health budgets

During the year, we developed a new policy for personal health budgets. Personal health budgets provide an amount of money to eligible individuals to support their identified health and wellbeing needs, which are planned and agreed between the person and their local NHS team. Our new policy, which will be in place from April 2016, supports us in delivering our duty to ensure that eligible patients have the right to request a personal health budget if they choose.

## Transforming care for people with learning disabilities

We have continued to contribute to Transforming Care plans – working with other CCGs through a North Mersey 'hub' – to improve services for people with learning disabilities and autism who display behaviour that challenges, including those with a mental health condition.

## Quality in care homes

We have been working closely with the Care Quality Commission (CQC) around its inspection programme of local care homes. Where the CQC has taken action to close a care home, we have supported the safe movement of those residents whose package of care we commission. Our quality team has also supported the education of care home staff in monitoring and assessing patients. During 2015-2015 our commitment to this area was strengthened by the appointment of a head of vulnerable people.

## Being prepared for emergencies

We have a role to play in supporting the management of emergencies such as major incidents, or natural events like flooding and pandemic flu. Our duties are set out in the Civil Contingencies Act 2004, which names CCGs as 'Category 2' responders. This means we are required to share information and cooperate with other agencies in planning for and responding to emergencies should they happen.  Like Category 1 responders, such as the police, fire service and Sefton Council, we must also produce plans to help us to assess risk

and ensure that arrangements are in place for informing and warning the public should this be necessary.

The NHS Core Standards for Emergency Planning, Response and Resilience further requires us to ensure that our service providers have plans in place to respond to and recover from emergencies. We gain operational support in meeting our duties from our Commissioning Support Unit through its Emergency Planning, Response and Resilience Team. Here are some of the ways we met our duties in 2015-2016:

- We are part of the Local Resilience Forum and the Local Health Residence Partnership – which bring a wide range of agencies together to plan for and coordinate the management of emergencies
- We work with CCGs and service providers across Merseyside to ensure the healthcare system can respond to incidents night and day – we have a 24/7 on call system, so service providers and other agencies can contact us round the clock in the event of emergencies
- We have developed business continuity and incident response plans - as well as making sure our own plans are robust, we monitor the plans of our service providers
- Our staff take part in regular training sessions and exercises – so we have the skills and experience to deal with unexpected incidents

### Health and safety

We are a low risk organisation with a positive health and safety culture. We have effective policies and procedures in place, which helps us to set and maintain sensible and proportionate standards of health and safety management. This ensures we effectively support the wellbeing of our staff and others who may be affected by our activities, and to minimise the losses to our organisation from ill health and injury.

# Involving you

We believe that involving south Sefton residents in our work is fundamental to achieving better heath and wellbeing. Our patients know the quality of existing health services from first hand experience, and the view of local people can help us to determine what more we need to do to achieve our aims.

## Involving you in our daily business

We have a number of statutory responsibilities[10] to make sure good, two way engagement and involvement is part of our daily business and our organisational structures reflect our commitment to this:

- We have a named **Governing Body lay member lead** for public engagement and involvement
- Our **Engagement and Patient Experience Group** (EPEG) reports to our Quality Committee. It is jointly chaired by our Governing Body lead and their counterpart from NHS Southport and Formby CCG, along with their elected practice manager leads. It includes representation from Healthwatch Sefton, Sefton Council and Sefton CVS, which represents the voluntary, community and faith sector. This group helps us to maximise the opportunities we have to engage across the different sectors in Sefton by working together in a coordinated way. EPEG gives expert advice about how and where to go to engage people. It collects the information we gather from all our engagement activities to inform our work, and patient experience to help us to gauge how effective our services are and where we can improve them. We produced our first EPEG annual report, showing how the group is helping us to meet our statutory duties around involvement
- Whenever it is appropriate, we invite **patient, public or carer representatives** to get directly involved in our day to day work and in 2015-2016 this included groups to improve respiratory services, cancer and procurement exercises
- A number of GP practices in south Sefton have **patient groups**. We are providing support to help more practices to set up their own group. These groups enable patients to have their say about services at their practice and hear about our wider work.
- We hold regular public **Big Chat** events where we bring people together to discuss our work, ask for their views about our plans and feedback how we have used people's comments and experiences so far
- We design and carry out specific **involvement exercises** for different aspects of our work, particularly when we are planning changes to a service now or in the future
- Our **governing body** and **annual general meetings** are open to all residents and provide further opportunities for people to hear more about our work, ask questions and find out about other ways they can get involved

[10] This includes the Health and Social Care Act, the NHS Constitution, the Equality Act 2010 and local council Overview and Scrutiny powers around service changes, along with guidance such as Transforming Participation in Health and Care and Everyone Counts – Planning for Patients

# Your involvement in 2015-2016

There are a number of different ways that we involve local people in our work. This could be tapping into our local voluntary, community and faith networks, or carrying out more focused work with specific communities and groups of people affected by our work.

Here are some examples from the year and you will find more on our website.

### Communicating health in south Sefton

During 2015-2016, we reviewed and refreshed our strategy for involving residents in our work. Our strategy sets out our approach to communicating, engaging and consulting with different groups and individuals – from our residents through to Sefton Council's overview and scrutiny panel for adult social care. We updated our strategy to reflect new national guidance that helps us to meet our duties around public and patient participation. In addition, we used the recommendations of a new participation plan from Sefton Young Advisers to inform how we might better capture and act on the voice of children and young people in all areas of our work.

### Big Chat 5 meets AGM

We combined our Big Chat 5 in September 2015 with our annual review, or AGM. The afternoon focused on community services. After hearing about our plans for these services, people were asked for their views and experiences of the care including blood testing, therapies, district nurses and community matrons. This built upon the feedback we received at Big Chat 4, which helped us to develop our model for community centred health and care.

### Community services review

We planned a programme of activities, which began at the end of 2015 to support a wider review of these services.  An equality impact assessment helped us to focus our activities on protected groups. With the support of our partners and their networks, we went out and about to speak with a range of people to capture their comments. In addition, we ran an online survey to capture the views of a much wider group of residents.

### Community dermatology service

Our team went into a number of clinics to better understand what patients think of the care provided by the community dermatology service. The results were used to inform improvements of this service ahead of a re-procurement exercise.

### Personal health budgets

We worked with Sefton Carers Centre to design a specific exercise to support our work to increase the take up of personal health budgets amongst those residents who are eligible. The exercise helped us to refine our patient information materials and to identify what additional support and advice people need about personal health budgets ahead of the implementation of our new policy in April 2016.

### Working voice

With Healthwatch Sefton and Sovini Housing we are looking at ways to increase opportunities for our residents of working age to get involved in their local NHS. Sovini is a major employer in Sefton and we have begun to tap into their workplace based engagement sessions to encourage participation in their local NHS. Additionally the housing association is also helping us to better share information about health and services with its tenants.

### Strengthening our systems

We were chosen to take part in a national project that began in 2015-2016, which will help us to better involve people in our work by ensuring their views more quickly and systematically inform our commissioning decisions. The Macmillan Improving Patient Experience programme is linking us with best practice and advice from around the country to support us developing a new system that we hope will be operational in 2016-2017. As well as recording people's views in one place, we hope this new system will help us to analyse all the data we collect to spot trends earlier, so we can act much quicker on people's information and feedback to them in a more timely way.

### Practice patient groups

We believe that practice patient groups are a good way to involve our residents in their local NHS. They offer a chance for people to get involved in making improvements to their GP practice as well as offering a gateway to being involved in our wider CCG work. From 2015-2016, all GP practices will be required to establish a patient group as part of their contract with NHS England and many south Sefton surgeries already have well established and thriving groups. During the year, we worked with Healthwatch Sefton to develop a pilot to better support practices in developing their groups. This will initially be tested in Maghull during 2016-2017.

# Equality and diversity

Promoting equality is at the heart of everything we do. We want to ensure that we commission services fairly, so that no community or group is left behind in the changes that we make to health services as we work towards the vision set out in our 5 year strategy and NHS England's 'Five Year Forward View'.

We continue to work internally and in partnership with our providers, community and voluntary sector and other key organisations to ensure that we advance equality of opportunity and meet our exacting requirements of the Equality Act 2010 during these difficult and challenging times.

You can read a full account of how we respond to our duties in our full equality and diversity annual report[11], which we publish on our website. It sets out how we pay 'due regard' to our public sector equality duty, which we consider daily as we make commissioning decisions on behalf of the population we serve.

### Our duties

We are required to prepare and publish equality objectives to meet our specific duty as outlined in the Equality Act 2010. Our objectives plan has been significantly revised in light or our equality delivery systems 2 assessment in 2015. Our plan is specific and measurable, and it is aimed at tackling a diverse range of barriers people who share protected characteristics face in relation to health services we commission and support.

Our equality objectives are:

- To make fair and transparent commissioning decisions
- To improve access and outcomes for patients and communities who experience disadvantage
- To improve the equality performance of our providers through robust procurement and monitoring practice
- To empower and engage our workforce

### Equality delivery systems 2

To help us set our equality objectives we undertook an innovative approach to our equality delivery systems (EDS) 2 toolkit and assessment, which involved extensive engagement with national, regional and local organisations that represent the interests of people who share protected characteristics. Information about EDS 2 is contained within our full annual equality and diversity report.

[11] www.southseftonccg.nhs.uk

## Provider performance

All our key NHS providers have undertaken the EDS 2 assessment and have set equality objectives in accordance with their requirements. We are working closely with our providers to improve equality performance and access and outcomes for protected groups through robust contract monitoring, via the quality contract schedule.

## Our staff

We have duties to meet under the Equality Act 2010 in relation to workforce and organisational development. We take positive steps to ensure that our policies deal with equality implications around recruitment and selection, pay and benefits, flexible working hours, training and development, policies around managing employees and protecting employees from harassment, victimisation and discrimination. It is mandatory for all our staff to complete equality training and, in addition, we have a workforce equality plan, which has contributed to us meeting the Workforce Race Equality Standard. In 2015-2016, we also continued to maintain our ‘positive about disabled people 2 tick’ accreditation.

# Working sustainably

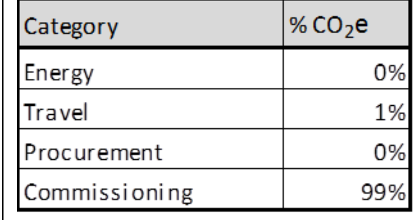
As an NHS organisation and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of the rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

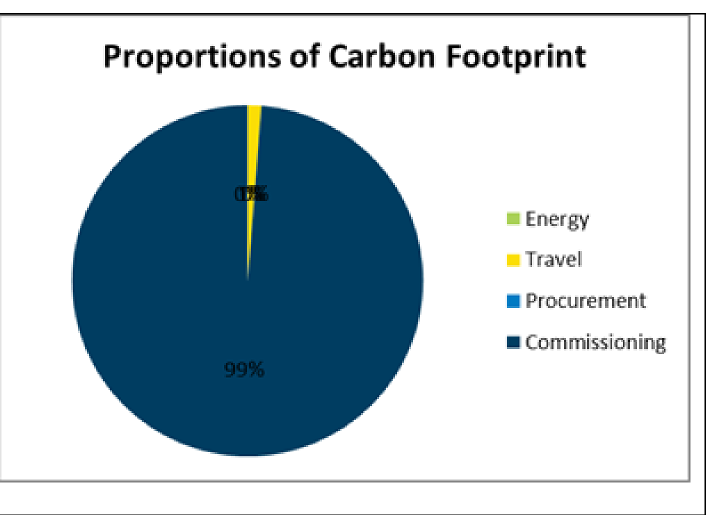
As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions by 28% by 2020 using 2013 as the baseline year.

**Modelled Carbon Footprint**

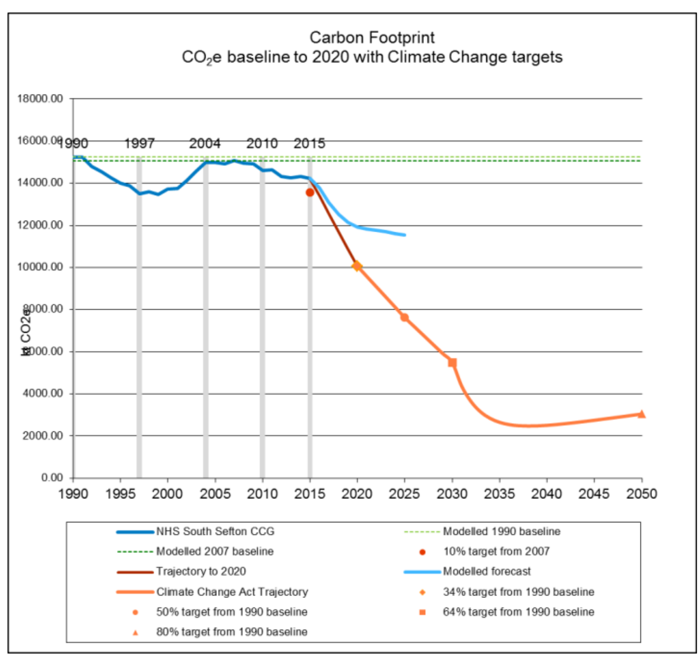
The majority of the environmental and social impacts are through the services we commission. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2014-2015[12]. This results in an estimated total carbon footprint of 14,479,157 tonnes of carbon dioxide equivalent emissions ($tCO_2e$).



| Category | % $CO_2e$ |
|---|---|
| Energy | 0% |
| Travel | 1% |
| Procurement | 0% |
| Commissioning | 99% |




[12] More information available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.asp




## Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

| Area | Is sustainability considered? |
|---|---|
| Commissioning (environmental) | Yes |
| Commissioning (social impact) | Yes |
| Suppliers' impact | Yes |
| Travel | No |

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

**Partnerships**

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

Strategic partnerships are already established with the following organisations: Southport and Formby CCG and Sefton Council. For commissioned services here is the sustainability comparator for our providers:

| Organisation Name | SDMP | On track for 34% reduction | GCC | Healthy travel plan | Adaptation | SD Reporting score |
|---|---|---|---|---|---|---|
| Aintree University Hospital NHS Foundation Trust | Yes | Yes | No | No | No | Excellent |
| Liverpool Community Health NHS Trust | Yes | No | Yes | Yes | No | Minimum |
| Mersey Care NHS Trust | No | No | Yes | Yes | No | Data not available |
| Southport and Ormskirk Hospital NHS Trust | Yes | No | No | No | No | Poor |
| Royal Liverpool and Broadgreen University Hospitals NHS Trust | Yes | Yes | Yes | Yes | Yes | Data not available |
| Alder Hey Children's NHS Foundation Trust | Yes | No | No | No | No | Excellent |

More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

We have a small workforce and a small headquarters, so we are a relatively low carbon emitting organisation. We lease our office in Bootle, and we will work with the owners of the building to provide all required information about carbon emissions in future years.

# Providing value

## Financial performance overview

The following summary financial statements set out the performance of NHS South Sefton CCG during the financial year 2015-16. For a full understanding of our financial position and performance, a complete set of financial statements is available from the South Sefton CCG websire:

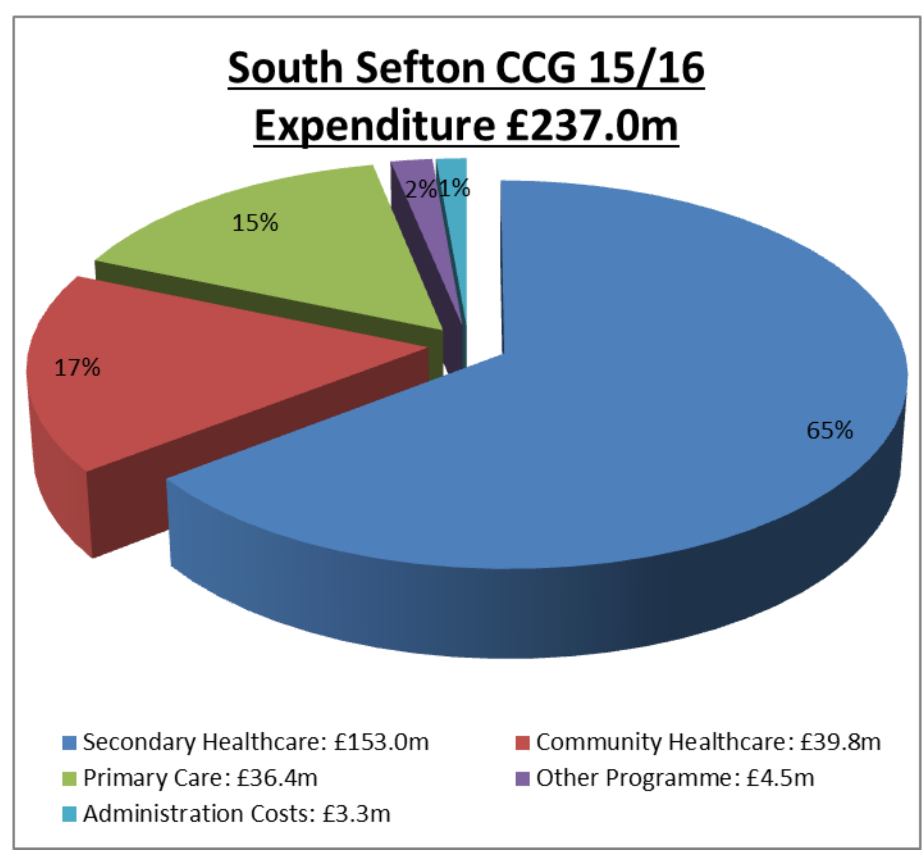
(http://www.southseftonccg.nhs.uk/get-informed/publications/)

We are pleased to report that all of our statutory financial duties 2015-16 have been achieved, notably:

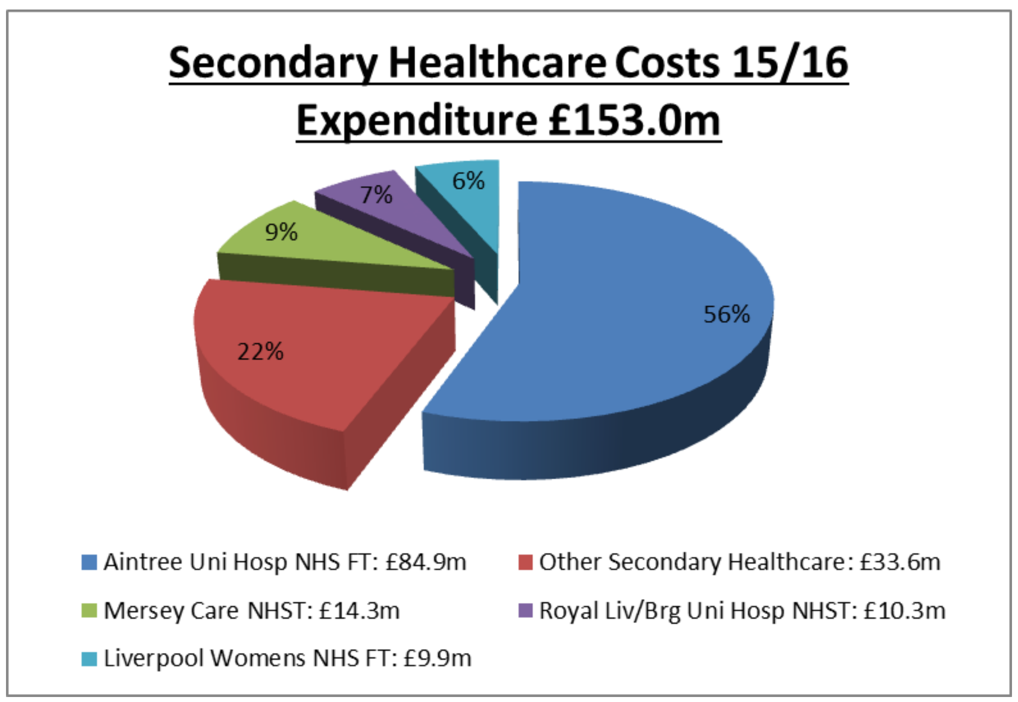
- Achieved 'operational financial balance' and reported a revenue surplus of £2.4m which is carried forward for investment in future years;
- Managed within our cash limits;
- Operated within our running cost allowance (administrative cost budget set by NHS England).

### Analysis of funding and expenditure

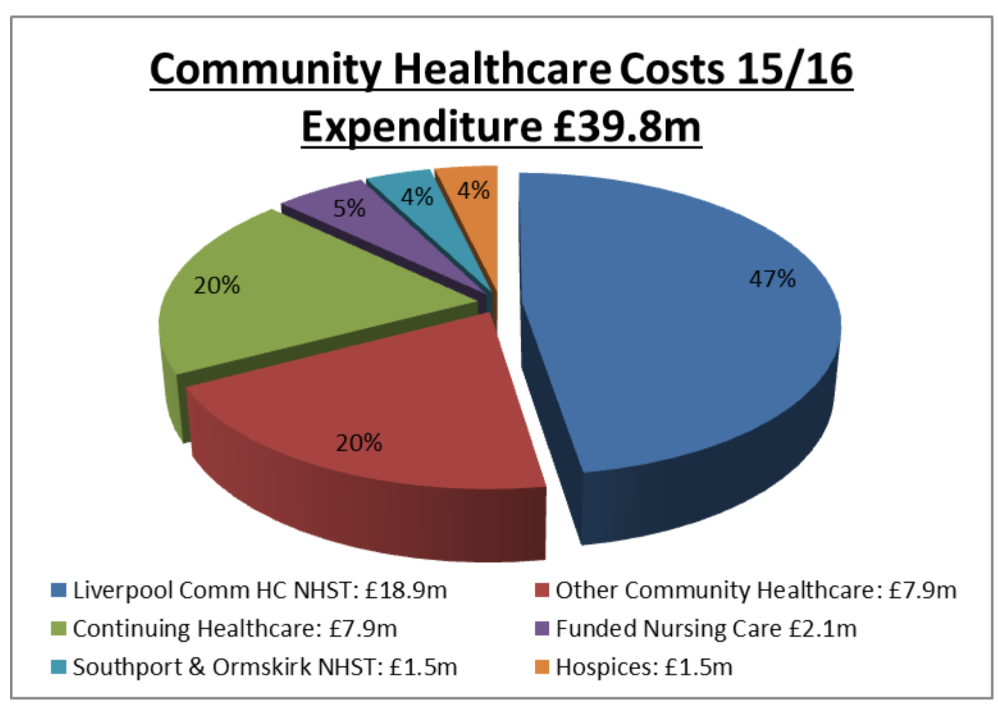
We received £239.4m of parliamentary revenue funding in 2015-16 of which we have carried forward £2.4m for future year investment in healthcare services. The remaining £237.0m was spent as follows:



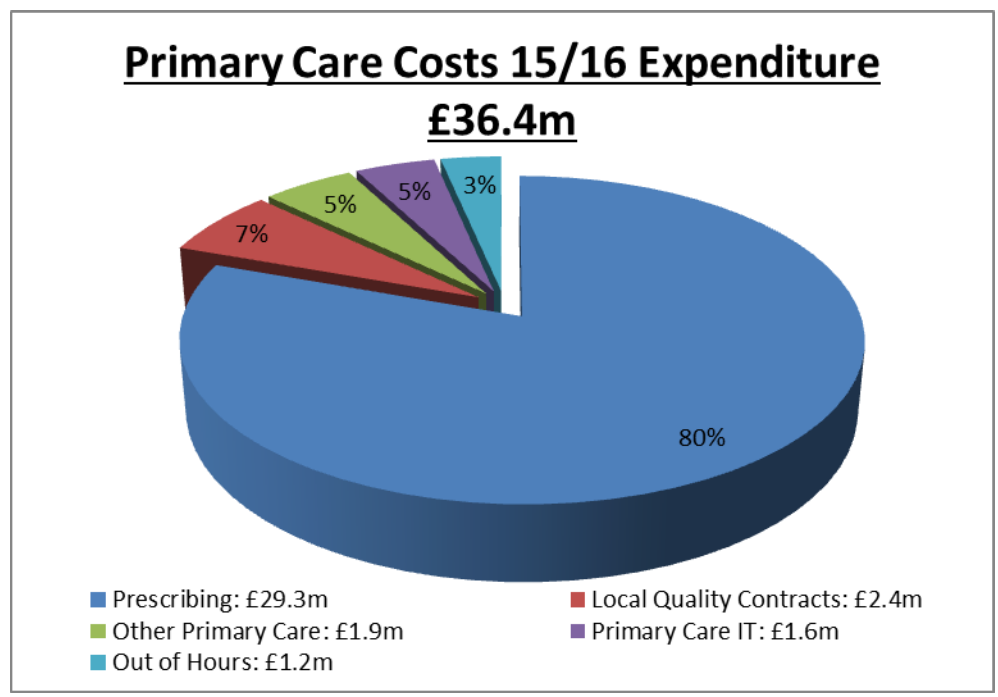
**Secondary healthcare -** represents the cost of contracts we have with hospitals to provide services for our population. Examples of these services include accident and emergency, maternity, mental illness and general and acute services. A breakdown of this spend by provider is shown below.




**Community healthcare -** is the cost of services provided in a community setting. Examples of this are district nursing, physiotherapy and community clinics. It also includes the cost of providing long term packages of care for people at home and in nursing and residential homes. A breakdown of this spend is shown below.



**Primary care costs -** mainly represent the cost of drugs prescribed by GPs. They also include some other services commissioned from GPs and primary care contractors (eg Out of Hours services). A breakdown of this spend is shown below.




**Other programme costs -** mainly consist of non-acute services such as re-ablement schemes and other mental health services, as well as front line IT schemes.

**Administration -** represents the departments that support the process of commissioning the healthcare services described above. By understanding the needs of our community, we strive to obtain high quality and valued services. We also ensure management of those contracts throughout the lifecycle of a service is of the highest possible standards. These costs represent just 1.4% of the CCG's overall budget.

The following summary statements show the key financial reports for the CCG.

**Statement of comprehensive net expenditure (summary)**

| £,000 | 2015/16 | | | 2014/15 | | |
|---|---|---|---|---|---|---|
| | Admin | Programme | Total | Admin | Programme | Total |
| Employee Benefits | 2,015 | 1,099 | 3,115 | 1,405 | 715 | 2,120 |
| Operating Expenses | 1,344 | 233,274 | 234,618 | 2,178 | 224,787 | 226,965 |
| Other operating revenue | (101) | (609) | (710) | 0 | (591) | (591) |
| Net Operating Expenditure | 3,258 | 233,764 | 237,022 | 3,584 | 224,911 | 228,495 |

This financial statement shows our total net expenditure split between direct healthcare spend (programme) and administrative spend.

### Statement of financial position (summary)

| £'000s | 2015-16 | 2014-15 |
|---|---|---|
| Non Current Assets | 28 | 43 |
| Current Assets | 2,096 | 1,680 |
| **Total Assets** | **2,125** | **1,723** |
| Current Liabilities | (17,405) | (17,920) |
| **Non Current Assets less Net Current Liabilities** | **(15,280)** | **(16,197)** |
| Non-Current Liabilties | 0 | (62) |
| **Assets less Liabilities** | **(15,280)** | **(16,259)** |
| | | |
| **Total Taxpayers Equity** | **(15,280)** | **(16,259)** |

The statement of financial position provides a snapshot of the CCG's assets and liabilities as at 31 March 2016. The negative balance reported against total taxpayers equity is a consequence of timing payments as opposed to any adverse financial performance.

### Statement of changes in taxpayers equity for the year ended 31 March 2016 (summary)

| Total Reserves | £'000s |
|---|---|
| Balance at 1st April 2015 | (16,259) |
| **Changes in NHS CCG Taxpayers Equity for 2015-16** | |
| Net Operating Expenditure for the financial year | (237,022) |
| **Net Recognised NHS CCG Expenditure for the financial year** | **(237,022)** |
| Net Funding | 238,001 |
| **Balance at 31st March 2016** | **(15,280)** |

This statement reflects the gains or losses that have not been reflected in the operating cost statement.

### Statement of cash flows for the year ended 31 March 2016 (summary)

| £'000s | 2015-16 | 2014-15 |
|---|---|---|
| **Cash Flows from Operating Activities** | | |
| Net Operating Expenditure for the financial year | (237,022) | (228,494) |
| Depreciation and Amortisation | 15 | 16 |
| (Increase)/Decrease in trade and other receivables | (461) | 432 |
| Increase/(Decrease) in trade and other payables | (425) | (785) |
| Increase/(Decrease) in provisions | (152) | 414 |
| **Net Cash Inflow / (Outflow) from Operating Activities** | **(238,046)** | **(228,417)** |
| | | |
| **Net Cash Inflow / (Outflow) from Investing Activities** | **0** | **0** |
| | | |
| **Net Cash Inflow / (Outflow) before Financing** | **(238,046)** | **(228,417)** |
| | | |
| Cash Flow from Financing Activities | | |
| Grant Aid Funding Received | 238,001 | 228,839 |
| **Net Cash Inflow / (Outflow) from Financing** | **238,001** | **228,839** |
| | | |
| Net Increase / (Decrease) in Cash and Cash Equivalents | (45) | (28) |
| | | |
| Cash and Cash Equivalents at the beginning of the Financial Year | 162 | 190 |
| **Cash and Cash Equivalents at the end of the Financial Year** | **117** | **162** |

This Statement explains the movements in cash balances during the financial year.

### Better Payment Practice Code

| | 2015-16 | | 2014-15 | |
|---|---|---|---|---|
| | Number | Value | Number | Value |
| Non NHS Payables | 91.6% | 92.6% | 90.6% | 89.2% |
| NHS Payables | 90.6% | 99.9% | 91.9% | 99.3% |

We are required to pay all trade creditors in accordance with the national Better Payment Practice Code (BPPC). The target is to pay relevant creditors within 30 days of receipt of goods or a valid invoice unless other payment terms have been agreed with the supplier. The CCG is a signatory to the Prompt Payment Code, details of which can be seen at www.promptpaymentcode.org.uk . The CCG is striving to improve its performance to ensure that it meets its targets in the future.

### Pensions liabilities

The full financial statements and accompanying notes and policies provide full details of the pension scheme.

### Audit Fees

KPMG are the auditors of NHS South Sefton CCG and the fees charged for 2015-15 were £45,000 (exc' VAT). No further fees were payable for additional, non-statutory work.

# Accountability report

Our organisational structure helps us to work effectively and commission the best healthcare possible, spending our share of NHS funding wisely. This section gives you more information about our Governing Body, member practices and staff. It also details the composition and roles of our most important committees.

# Members report

### Governing Body membership

The table below shows the people who made up our Governing Body in 2015-2016, their roles and the committees[13] they were a part of.

| Name | Role | Governing Body | Audit Committee | Finance and Resources Committee | Remuneration Committee | Quality Committee |
|---|---|---|---|---|---|---|
| **Dr Craig Gillespie** | Clinical Chair, GP | Yes | | | Yes | Chair |
| **Dr Andrew Mimnagh** | Clinical Vice Chair | Yes | | Yes | Yes | Yes |
| **Graham Morris** | Vice Chair & Lay Member, Finance Management & Audit | Yes | Chair | Yes | Chair | |
| **Dr Clive Shaw** | GP Clinical Director | Yes | | | | |
| **Dr Clive Shaw** | GP Clinical Director | Yes | | | | |
| **Lin Bennett** | Practice Manager | Yes | Yes | | Yes until 27/03/2015 | Yes until 27/03/2015 |
| **Fiona Taylor** | Chief Officer | Yes | | Ex officio member | | Ex officio member |
| **Roger Driver** | Lay Member, Engagement and Patient Experience | Yes | Yes | Chair | Yes | |
| **Debbie Fagan** | Chief Nurse | Yes | | Yes | Yes | Yes |
| **Dr Dan McDowell** | Secondary Care Doctor | Yes | Yes | | | |

[13] More details about members of the Governing Body and any conflicts of interest can be found on page 63 in the Remuneration Report.

| Name | Role | Governing Body | Audit Committee | Finance and Resources Committee | Remuneration Committee | Quality Committee |
|---|---|---|---|---|---|---|
| **Martin McDowell** | Chief Finance Officer | Yes | | Yes | | Yes |
| **Sharon McGibbon** | Practice Manager | Yes | | Yes | | |
| **Dr Paul Thomas** | GP Clinical Director | Yes | | Yes | | |
| **Dr John Wray** | GP Clinical Director | Yes | | Yes | | |
| **Dr Ricky Sinha** | GP Clinical Director | Yes | | | Yes | |
| **Tanya Mulvey** | Practice Manager | July 2015 till Nov 2015 | | | July 2015 till Nov 2015 | |

## Governing body profiles

The table below sets out for the Governing Body members the declared interests and conflicts together with the date declared.

| Name | Clinical / Business role on the Governing Body | Declared Interests and Conflicts | Nature of Interest | Date Declared |
|---|---|---|---|---|
| **Dr Craig Gillespie** | Governing Body Chair<br>Lead for CVD | GP Partner, Blundellsands Surgery | Personal | 24 Sep 2015 |
| **Dr Andy Mimnagh** | GP Governing Body Member and Clinical Vice Chair | GP Partner, Eastview Surgery<br>Liverpool Health | Personal<br><br>Family | 24 Sep 2015<br><br>24 Sep 2015 |
| **Graham Morris** | Governing Body Vice Chair and Lay Member from 1 Dec 2013 | None | | 24 Sep 2015 |
| **Dr John Wray** | GP Governing Body Member | GP Partner, Westway Medical Practice | Personal | 29 Sep 2014 |
| **Dr Pete Chamberlain** | GP Clinical Director and Governing Body Member | Alder Hey NHS Trust | Family | 24 Sep 2015 |
| **Dr Clive Shaw** | GP Governing Body Member | GP Partner, 30 Kingsway | Personal | 16 May 2013 |
| **Dr Paul Thomas** | GP Governing Body Member | GP Partner, High Pastures Surgery<br>Director, ENC Medical Services | Personal<br><br>Personal | 24 Sep 2015<br><br>24 Sep 2015 |
| **Dr Ricky Sinha** | GP Governing Body Member | GP Partner, North Park Health Centre<br>Dream Solutions | Personal<br>Personal | 24 Sep 2015<br>24 Sep 2015 |
| **Dr Dan McDowell** | Governing Body Member<br>Hospital Medical Representative | None | | 24 Sep 2015 |
| **Lin Bennett** | Practice Manager Governing Body Member<br>Chair of CCG Practice Managers Group | Practice/Business Manager Ford Medical Practice | Personal | 30 Sep 2014 |
| **Sharon McGibbon** | Practice Manager Governing Body Member | Practice Manager Eastview Surgery<br>Self Employed Contractor, Driver Trainer/Risk Assessor Sefton MBC | Personal<br>Family | 24 Sep 2015<br>24 Sep 2015 |
| **Canon Roger** | Lay Member Governing Body | Minister in the Church of England | Personal | 13 May 2013 |

| Name | Clinical / Business role on the Governing Body | Declared Interests and Conflicts | Nature of Interest | Date Declared |
|---|---|---|---|---|
| **Driver** | Co-Chair of EPEG | Chair Sefton Health & Social Care Forum<br>Team Rector, Bootle Team Ministry<br>Area Dean, Bootle Deanery<br>Hon Canon, Liverpool Cathedral<br>Trustee, Together Liverpool<br>Chair Sefton Council Independent | Personal<br>Personal<br>Personal<br>Personal<br>Personal<br>Personal | 13 May 2013<br>13 May 2013<br>13 May 2013<br>13 May 2013<br>13 May 2013<br>13 May 2013 |
| **Fiona Taylor** | Chief Officer Governing Body Member | Dual role as Chief Officer between South Sefton CCG and Southport and Formby CCG | Personal | Mar 2016 |
| **Debbie Fagan** | Chief Nurse Governing Body Member | Dual role as Chief Nurse between South Sefton CCG and Southport and Formby CCG | Personal | 9 Mar 2016 |
| **Martin McDowell** | Chief Finance Officer Governing Body Member | Dual role as Chief Finance Officer and Deputy Chief Officer between South Sefton CCG and Southport and Formby CCG<br>St Helens and Knowsley NHS Trust Employee | Personal<br>Family | 30 Dec 2015<br>30 Dec 2015 |

## Managing information securely

The Quality Committee ensures that any information we hold about our patients' care is held securely and in line with data protection legislation and wider information governance requirements. We did not report any data breaches to the Office of the Information Commissioner in 2015-2016. If breaches do occur, we work hard to strengthen our systems, and our staff carry out regular training to ensure their work complies with national standards and regulations.

## Members’ declaration

Each member knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

# Certifications by our accountable officer

We certify that the performance report, members' report and remuneration report presented as part of the CCG's Annual Report have been prepared in accordance with the guidance contained in the NHS England Annual Accounts Guidance 2015-16 issued on 23 March 2016 and the Department of Health Group Manual for Accounts updated March 2016.

We certify that the CCG has complied with the statutory duties laid down in the NHS Act 2006 (as amended).

We certify that the classification as a senior manager as defined by the Government Financial Reporting Manual, only extends to membership of the CCGs Governing Body.

We certify that the CCG has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

We certify that the CCG has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The CCG regularly reviews and makes improvement to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

Each individual who is a member of the Governing Body at the time that the members' Report is approved confirms:

- So far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware: and,
- That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

**Fiona Taylor**

**Chief Officer (Accountable Officer)**

**NHS South Sefton CCG**

**May 2016**

# Statement of accountable officer's responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Fiona Taylor to be the Accountable Officer of the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the *Manual for Accounts* issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards as set out in the *Manual for Accounts* issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,

- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Fiona Taylor

Accountable Officer

26 May 2016

# Governance statement

## Introduction and context

The clinical commissioning group, or CCG, was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

The clinical commissioning group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commission group taking on its full powers.

As at 1 April 2013, the clinical commissioning group was licensed **without** conditions.

The clinical commissioning group is a clinically led membership organisation made up of general practices.

The functions that the group is responsible for exercising are set out in the Health and Social Care Act 2012.

1. commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   a) all people registered with member GP practices, and
   b) people who are usually resident within the area and are not registered with a member of any clinical commissioning group
2. commissioning emergency care for anyone present in the group's area;
3. paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the group's employees
4. determining the remuneration and travelling or other allowances of members of its Governing Body

## Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

## Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the clinical commissioning group's continued aspirations to comply with the principles set out in code.

For the financial year ended 31 March 2016, and up to the date of signing this statement, we continued to work towards full compliance with the provisions set out in the code, and to apply the principles of the code.

## CCG Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

*The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.*

The CCG comprises membership from the practices in the following table[14].

| Practice name and address | |
|---|---|
| **15 Sefton Road** | 15 Sefton Road, Litherland, Liverpool , Merseyside, L21 9HA |
| **42 Kingsway** | 42 Kingsway, Waterloo, L22 4RQ |
| **Aintree Road Medical Centre** | 1B Aintree Road, Bootle, Liverpool, L20 9DL |
| **Azalea Surgery** | 20 Kingsway, Waterloo, L22 4RQ |
| **Blundellsands Surgery** | 1 Warren Road, Blundellsands, Liverpool, L23 6TZ |
| **Bootle Village Surgery** | 204 Stanley Road, Bootle, L20 3EW |
| **Bridge Road Medical Centre** | 66-88 Bridge Road, Litherland, Liverpool, L21 6PH |
| **Concept House Surgery** | 17 Merton Road, Bootle, Merseyside, L20 3BG |
| **Crosby - SSP Health Limited (Dr Maaserani Is Interim Provider)** | 3 Little Crosby Road, L23 2TE |
| **Crossways SSP Health Ltd (Dr Maaserani Is Interim Provider)** | 168 Liverpool Road, Crosby, L23 0QW |
| **Eastview Surgery** | 81-83 Crosby Road North, Waterloo, L22 4QD |

[14] Our membership reduced in 2015-2016 from 33 to 31 practices through the merger of Broadwood Surgery with Westway Medical Centre due to retirement and the closure of Litherland Primary Care Walk-in Service

| | |
|---|---|
| **Ford Medical Practice** | 91-93 Gorsey Lane, Litherland, Liverpool, L21 0DF |
| **Glovers Lane Surgery** | Glovers Lane, Netherton, L30 5TA |
| **High Pastures Surgery** | 138 Liverpool Road North, Maghull, L31 2HW |
| **Hightown - SSP Health Limited (Formby Village Surgery Is Interim Provider)** | St Georges Road, L38 3RY |
| **Kingsway Surgery** | 30 Kingsway, Waterloo, L22 0QW |
| **Litherland - SSP Health Limited (Dr Maaserani Is Interim Provider)** | Hatton Hill Road, Litherland, Liverpool, Merseyside, L21 9JN |
| **Liverpool Rd Medical Practice** | 133 Liverpool Road, Crosby, Liverpool, Merseyside, L23 5TE |
| **Maghull Health Centre** | Maghull Family Health Centre, Maghull, L31 0DJ |
| **Maghull Health Centre** | Maghull Health Centre, Maghull, L31 0DJ |
| **Moore Street Medical Centre** | 77 Moore Street, Bootle, Liverpool, L20 4SE |
| **Netherton - SSP Health Limited** | Netherton Health Centre, Magdalen Square, Bootle, Merseyside, L30 5SP |
| **North Park Health Centre** | 290 Knowsley Road, Bootle, Merseyside, Liverpool, L20 5DQ |
| **Orrell Park Medical Centre** | Trinity Church, Orrell Lane, Liverpool, L9 8BU |
| **Park Street Surgery** | Park Street, Bootle, Liverpool, L20 3DF |
| **Parkhaven SSP Health Limited (Dr Maaserani Is Interim Provider)** | Parkhaven Trust, Liverpool Road South, L31 3RY |
| **Rawson Road Medical Centre** | 136-138 Rawson Rd, Liverpool, L21 1HP |
| **Seaforth SSP Health Ltd (Dr Maaserani Is Interim Provider)** | 20 Seaforth Road, Liverpool, Merseyside, L21 3TA |
| **Sefton Road Surgery** | 129 Sefton Road, Litherland, Liverpool, Merseyside, L21 9HG |
| **The Strand Medical Centre** | 272 Marsh Lane, Bootle, L20 5BW |
| **Thornton - SSP Health Limited (Formby Village Is Interim Provider)** | Bretlands Road, Thornton, L23 1TQ |
| **Westway Medical Centre** | Westway Medical Centre, Maghull, L31 0DJ |

Interim providers are currently in place at SSP Health Limited practices due to an ongoing re-procurement of the SSP Health Limited contract by NHSE.

The clinical commissioning group is a clinically led membership organisation made up of general practices. The member practices of the CCG are responsible for determining the governing arrangements for the organisation which are set out its Constitution[15].

The Constitution has been developed to reflect and support the objectives and values defined by the CCG and to ensure that all business functions discharged by the CCG are discharged in an open and transparent manner and the Constitution has been developed with the member practices and localities.

The CCG functions in respect of the geographical area defined as South Sefton.

The Governing Body comprises a diverse range of skills from executive and lay members and there is a clear division of responsibility between running the Governing Body and running the operational elements of the CCG's business.

The chair is responsible for the leadership of the Governing Body and ensures that directors have had access to relevant information to assist them in the delivery of their duties. The lay members have actively provided scrutiny and challenge at Governing Body and sub-committee level.

Each committee comprises membership and representation from appropriate officers and lay members with sufficient experience and knowledge to support the committees in discharging their duties.

The Governing Body has been well attended by all directors and lay members throughout the year ensuring that the Governing Body has been able to make fully informed decisions to support and deliver the strategic objectives.

The Governing Body is assured of its effectiveness in terms of performance management through the regular corporate performance reports on finance, quality and key performance indicators as set out in national guidance. Throughout the year performance has continued to be maintained or improved which represents a significant achievement.

The Governing Body was assured of its effectiveness by holding development sessions with an external provider that enabled discussion and reflection on performance, achievement of objectives, future programmes of work and on the effective leadership of Governing Body in delivering the CCG's strategy.

The Governing Body is supported by a sub-committee structure comprising the committees listed below.

[15] NHS South Sefton Clinical Commissioning Group *Constitution* (November 2014)

## Quality Committee

This committee has delegated responsibility for monitoring the quality of commissioned services, compliance with Controlled Drugs Regulations 2013, considering information from governance, risk management and internal control systems and; provides corporate focus, strategic direction and momentum for governance and risk management.

The committee reviews and scrutinises the Governing Body assurance framework (GBAF) and the corporate risk register. The committee has delegated responsibility for the approval of corporate policies and during the year has received updates and requests for approvals on the key following policies and processes:

- Information governance
- Serious incidents
- Health and safety
- Adult and children safeguarding
- Risk management
- Governing Body assurance framework
- An assessment of the Committee's effectiveness

The committee also reviewed and scrutinised the following:

- Early warning dashboards
- Provider quality reports
- Safeguarding arrangements
- Complaints management arrangements
- Complaints trends

The committee comprises the Chief Nurse, CCG officers, lay members, clinicians and other CCG officers to ensure that the committee is appropriately skilled and resourced to deliver its objectives.

The Quality Committee has been well attended by all CCG officers, lay members and clinicians throughout the year ensuring that there has been robust scrutiny and challenge at all times. This has enabled the Quality Committee to provide robust assurances to the Governing Body and to inform the Governing Body of key risk areas.

| Name | Title | April 15 | May 15 | June 15 | July 15 | Aug 15 | Sept 15 | Oct 15 | Nov 15 | Dec 15 | Jan 16 | Feb 16 | Mar 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Dr Gina Halstead** | Chair (w.e.f. May) and Clinical Lead for Quality | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ |
| **Steve Astles** | Head of CCG Development | A | ✓ | | | ✓ | A | A | ✓ | ✓ | A | ✓ | A |
| **Dr Peter Chamberlain** | Clinical lead Strategy & Innovation | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | A | ✓ | A |
| **Malcolm Cunningham** | Head of Contract and Procurement | ✓ | ✓ | | | A | A | A | A | ✓ | A | A | A |
| **Roger Driver** | Lay Member | A | ✓ | | | A | L | ✓ | ✓ | A | A | A | |
| **Debbie Fagan** | Chief Nurse & Quality Officer | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | A | L | ✓ | ✓ |
| **Dr Dan McDowell** | Secondary Care Doctor | A | A | | | A | L | ✓ | ✓ | ✓ | ✓ | A | A |
| **Martin McDowell** | Chief Finance Officer | ✓ | ✓ | | | A | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Sharon McGibbon** | Practice Manager/ Governing Body Member | A | A | | | ✓ | A | A | A | A | A | A | |
| **Dr Andrew Mimnagh** | Clinical Vice - Chair | ✓ | ✓ | | | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | A |
| **Dr Craig Gillespie** | Chair and Governing Body Member | ✓ | | | | | | | | | | | |

| ✓ Present | A Apologies | L Late or left early |
|---|---|---|

**Key highlights: during the year the Quality Committee:**

- Provided assurance to the Governing Body on the objectives and controls within the Governing Body assurance framework and corporate risk register
- Provided assurance of compliance with the information governance toolkit
- Approved safeguarding arrangements
- Approved corporate and clinical policies
- Approved complaints management arrangements
- Reviewed Continuing Health Care systems and processes. Internal Audit provided significant assurance on the arrangements in place

The committee is supported by a Corporate Governance Support Group, Engagement and Patient Experience Group, SMOOG and Serious Incident Review Group.

## Audit Committee

The Codes of Conduct and Accountability, issued in April 1994, set out the requirement for every NHS Board to establish an Audit Committee. That requirement remains in place today and reflects not only established best practice in the private and public sectors, but the constant principle that the existence of an independent Audit Committee is a central means by which a Governing Body ensures effective internal control arrangements are in place.

The principal functions of the Committee are as follows:

- To support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities to support the delivery of the CCG's objectives; and
- To review and approve the arrangements for discharging the CCG's statutory financial duties

The Audit Committee met five times during 2015/16 in April, May (to sign off the accounts), July, October and January.

The Committee comprises four members of the Clinical Commissioning Group Governing Body:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience & Engagement)
- Practice Manager Governing Body Member
- Secondary Care Doctor

The Audit Committee Chair and one other member will be necessary for quorum purposes. In addition to the Committee Members, Officers from the CCG are also asked to attend the committee. The core attendance comprises:

- Chief Finance Officer
- Chief Nurse & Quality Officer
- Head of Corporate Delivery and Integration
- Deputy Chief Finance Officer
- Chief Accountant

In carrying out the above work, the Committee primarily utilises the work of Internal Audit, External Audit and other assurance functions as required. A number of representatives from external organisations have attended to provide expert opinion and support:

- Audit Manager MIAA
- Local Counter Fraud Officers MIAA
- Audit Directors PWC and KPMG
- Audit Managers PWC and KPMG

The Audit Committee supports the Governing Body by critically reviewing governance and assurance processes on which the Governing Body places reliance. The work of the Audit Committee is not to manage the process of populating the Assurance Framework or to become involved in the operational development of risk management processes, either at an overall level or for individual risks; these are the responsibility of the Governing Body supported by line management. The role of the Audit Committee is to satisfy itself that these operational issues are being carried out appropriately by line management.

Attendance at the meetings during 2015/16 was as follows:

| Name | Membership | April 15 | May 15 | July 15 | Oct 15 | Jan 16 |
|---|---|---|---|---|---|---|
| **Graham Morris** | Lay Member (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Roger Driver** | Lay Member | A | ✓ | A | A | ✓ |
| **Dan McDowell** | Secondary Care Doctor | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Sharon McGibbon** | Practice Manager | A | A | N | | |
| ***In attendance:*** | | | | | | |
| **Martin McDowell** | Chief Finance Officer | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Debbie Fagan** | Chief Nurse & Quality Officer | ✓ | A | A | ✓ | ✓ |
| **David Smith** | Deputy Chief Finance Officer | ✓ | ✓ | A | A | ✓ |
| **Tracy Jeffes** | Head of Corporate Delivery and Integration | A | N | N | ✓ | A |
| **Ken Jones** | Chief Accountant | ✓ | ✓ | A | ✓ | |
| **Leah Robinson** | Chief Accountant | | | | | ✓ |
| **Roger Causer** | Senior Local Counter Fraud Specialist, MIAA | N | N | ✓ | N | A |
| **Wendy Currums** | Local Counter Fraud Specialist, MIAA | ✓ | N | N | | |
| **Michelle Moss** | Local Counter Fraud Specialist, MIAA | ✓ | N | ✓ | ✓ | ✓ |
| **Adrian Poll** | Audit Manager, MIAA | ✓ | N | ✓ | ✓ | ✓ |
| **Elizabeth Tay** | Audit Manager, PricewaterhouseCoopers | N | ✓ | N | | |
| **Mark Jones** | Audit Director, PricewaterhouseCoopers | A | ✓ | ✓ | | |
| **Ian Roberts** | Senior Manager, PricewaterhouseCoopers | ✓ | N | N | | |
| **Amanda Latham** | Audit Director KPMG | | | | | ✓ |
| **Jillian Burrows** | Audit Senior Manager KPMG | | | ✓ | ✓ | A |

✓ Present A Apologies N Non- attendance

## Internal Audit

**Role** - An important principle is that internal audit is an independent and objective appraisal service within an organisation. As such, its role embraces two key areas:

- The provision of an independent opinion to the Accountable Officer (Chief Officer), the Governing Body, and to the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements

During 2015/16 Mersey Internal Audit Agency (MIAA) have reviewed the operations of the CCG, have found no major issues and concluded that overall it has met its requirements. They have reported back on a number of areas. In all cases action plans have been implemented and are being monitored. In all areas reviewed to date 'Significant Assurance', has been reported. There were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the review objective. Regular progress reports will continue to be provided to each Audit Committee meeting.

**External Audit**

**Role** - The objectives of the External Auditors are to review and report on the CCG's financial statements and on its Statement on Internal Control.

External Audit (KPMG) has reported the outcome of the External Audit of the CCG's annual accounts, and the opinion has been included in this Annual report. This will be followed by the publication of the Annual Audit Letter to the Governing Body in its July meeting.

**Counter fraud specialist**

**Role -** The CCG is committed to taking all necessary steps to counter fraud, bribery and corruption. To meet its objectives, it has adopted the four-stage approach developed by the NHS Protect:

- **Strategic Governance** – This section sets out the standard in relation to the organisations strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organization
- **Inform and Involve** – This section sets out the requirement in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS
- **Prevent and Deter** – This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensure that opportunities for crime are minimized
- **Hold to Account** – This section sets out the requirement in relation to detecting crime and investigating crime. Prosecuting those who have committed crime and seeking redress

The Anti-Fraud Specialist presented the Audit Committee with a plan for approval during 2015/16 and has provided regular updates at meetings showing progress against the agreed plan.

**Regular Items for Review**

The Audit Committee follows a work plan approved at the beginning of the year, which includes, as required:

- Losses and special payments
- Outstanding debts
- Financial policies and procedures
- Tender waivers
- Declarations of interest
- Self-assessment of Committee's effectiveness

- Information Governance Toolkit
- Risk Registers

**Key Items in the Year for Noting**

- Annual Governance Statement approved
- Annual Accounts approved
- Annual Report approved
- ISA 260 unqualified audit report from PWC for 2014/15

**Conclusions**

The Audit Committee remains a key committee of the Governing Body, with significant monitoring and assurance responsibilities requiring commitment from members and support from a number of external parties. The annual work plan has been developed in line with best practice described in the Audit Committee Handbook and forms the basis of our meetings. In all of these areas the Audit Committee seeks to assure the CCG that effective internal controls are in place and will remain so in the future. In summary the work of the Audit Committee, in the third financial year in which the CCG has been in existence, continues to provide assurance to the Governing Body:

- An effective system of integrated governance, risk management and internal control is in place to support the delivery of the CCGs objectives and that arrangements for discharging the CCGs statutory financial duties are established
- There were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the review objective
- ISA260 Audit Highlights Memorandum has been reported by KPMG to the May Audit Committee Meeting as part of the Annual Accounts approval process. This will be followed by the publication of the Annual Audit Letter to the Governing Body in its July meeting

## Remuneration Committee

The committee ensures compliance with statutory requirements and undertook reviews of very senior managers' remuneration and to comply with the requirements set out in the NHS Codes of Conduct and Accountability and the Higgs report.[16] The committee reviews and agrees appraisal and remuneration of CCG officers.

During the year the committee has agreed contracts of employment and to adopt agenda for change terms and conditions, CCG senior manager benefit schemes, and to consider pay for Very Senior Managers (VSM). The Remuneration Committee met in full quorum for all meetings during the year.

[16] D, Higgs (January 2003) *Review of the Role and Effectiveness of non-executive directors* section 13.8 at page 61 – available at http://www.berr.gov.uk/files/file23012.pdf

### Finance and Resources Sub Committee

The committee oversees and monitors financial and workforce development strategies; monitors the annual revenue budget and planned savings; develops and delivers capital investment; is responsible for reviewing financial and workforce risk registers; and financial, workforce and contracting performance.

### Service Improvement and Redesign Committee

This committee was disestablished and incorporated into the newly formed QIPP committee in May 2015.

### QIPP Committee

This committee was established in May 2015 and incorporated the principal functions of the previous Service Improvement and Redesign Committee.

This committee is established as a sub-committee of the Governing Body to enable thorough and open discussion about all service improvement and redesign priorities of the CCG, in addition to identifying the required CCG efficiencies.

It provides a forum for the CCG localities, their practices clinical leads, Clinical Directors, CCG locality leads and practice representatives to identify potential areas of improvement and support plans and proposals for implementation.

## CCG Risk Management Framework

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;
- prevent and deter risks from arising by ensuring there is sufficient resource and capacity to support the CCGs strategy and objectives;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

The Governing Body has developed the corporate objectives, and the evaluation of the risks to achieving these objectives are set out in the Governing Body Assurance Framework which is regularly reviewed and scrutinised by the senior management team, Corporate Governance Support Group, Quality Committee, Audit Committee and the Governing Body. The Governing Body Assurance Framework is a key document whose purpose is to provide the Governing Body with 'reasonable' assurance that internal systems are functioning effectively. It is a high level document that is used to inform and give assurance to the Governing Body that the risks to achieving key objectives are recognised and that controls are in place or being developed to manage these risks.

The senior management team has responsibility for ensuring that all objectives are appropriately resourced to secure delivery and to mitigate risks to delivery arising.

To ensure that there are effective controls in place to deter and prevent fraud the CCG has appointed a Counter Fraud Specialist (CFS). The CFS undertakes an approved programme of work with the CCG ensuring that there are appropriate controls and mechanisms in place.

Risks are rated, and controls that will address these risks are identified, gaps in control or assurance are noted and action plans to close gaps summarised and updated. Potential and actual sources of assurance are identified and the latter are also rated for the level of assurance provided. A summary of the assurance levels for all assurance framework entries is updated each quarter and accompanies the full document. The corporate risk register provides the Governing Body with a summary of the principal risks facing the organisation, with a summary of the actions needed and being taken to reduce these risks to an acceptable level. The information contained in the corporate risk register should be sufficient to allow the Governing Body to be involved in prioritising and managing major risks. The risks described in the corporate risk register will be more wide-ranging than those in the Governing Body assurance framework, covering a number of domains.

Where risks to achieving organisational objectives are identified in the corporate risk register these are added to the Governing Body assurance framework; and where gaps in control are identified in the Governing Body assurance framework, these risks are added to the corporate risk register. The two documents thus work together to provide the Governing Body with assurance and action plans on risk management in the organisation. The corporate risk register is updated and presented for review and scrutiny at the same time as the Governing Body assurance framework.

The CCG commissions a range of training programmes which include specific mandatory training for particular staff groups which aims to minimise the risks inherent in their daily work. Information governance, counter fraud, fire, health and safety, equality and diversity and safeguarding training are mandatory training requirements for all staff. Targeted training is provided to designated risk leads to support development of risk registers, and one to one sessions are available for all managers responsible for updating the Governing Body assurance framework.

To ensure that there is a mechanism for public stakeholders to assist in the management of risks that impact on the public, the CCG has established an Experience and Public Engagement Group (EPEG). This group reviews any proposals for service change ensuring compliance with the Public Sector Equality Duty and other relevant laws before progressing further with consultation.

The CCG also consults with the Overview and Scrutiny Committee on any proposals potentially impacting on the public so that there is holistic and system wide assessment and mitigation of risks.

## CCG Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the

impact should they be realised, and to manage them, efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk;

The risk management agenda is co-ordinated through the senior management team, reporting to the Quality Committee and Governing Body. The Governing Body regularly reviews the corporate risk register/assurance framework to provide the Governing Body with 'reasonable' assurance that the internal systems are functioning effectively. By design this is a high level document that is used to inform and give assurance to the Governing Body that the risks to achieving key objectives are recognised and that controls are in place or being developed to manage those risks.

Risks are rated, and controls that will address these risks are identified, gaps in control or assurance are noted and action plans to close gaps summarised and updated. Potential and actual sources of assurance are identified and the latter are also rated for the level of assurance provided. The CCG commissions a range of training programmes which include specific mandatory training for particular staff groups which aim to minimise the risks inherent in their daily work activities. Information Governance training is mandatory for all staff. Targeted training is provided to designated risk leads to support the development of risk registers.

**Information Governance**

All key information assets have been identified by the information asset owners on an information asset register. The data security and confidentiality risks to each asset have been identified, and controls identified to mitigate risks.

The risks to the physical information assets are minimal, and pose no significant information governance concern for the CCG.

All inbound and outbound flows of data have been identified through a data flow mapping tool. All data flows are being transferred appropriately.

The risks to the inbound and outbound flows of data are minimal, and pose no significant information governance concern for the CCG.

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an Information Governance Toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have robust information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have

implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents.

The Chief Finance Officer is the CCG's Senior Information Risk Owner (SIRO) and the Chief Nurse is the CCG's Caldicott Guardian.

### Pensions Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

### Equality, Diversity and Human Rights Obligations

Control measures are in place to ensure that the clinical commissioning group complies with the required public sector equality duty set out in the Equality Act 2010.

### Sustainable Developments Obligations

The CCG is developing plans to assess risks, enhance performance and reduce its impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. As Accountable Officer I will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012. The CCG will also set out its commitments as a socially responsible employer.

## Risk Assessment in relation to Governance, Risk Management and Internal Control

NHS South Sefton CCG has a comprehensive risk management strategy. The following key elements are contained within the strategy:

- Risk management strategy aims and objectives
- Roles, responsibilities and accountability
- The risk management process – risk identification, risk assessment, risk treatment, monitoring and review, risk prevention
- Risk grading – criteria
- Training and support

NHS South Sefton CCG has established a number of mechanisms for identifying and managing risks including risk profiling methodology, incident reporting, complaints and litigation data, and staff concerns or whistleblowing.

Risk management and the ensuing development of risk registers is generally achieved using a dual 'top-down' and 'bottom-up' approach to identifying and managing risks. The 'top-down' element has been addressed through the development of a Governing Body assurance framework and corporate risk register identifying strategic high-level risks. These two documents are based on models which have previously been accepted as meeting audit requirements.

Key new risks identified during 2015/16 are

- Risk of poor quality patient care as a result of not delivering against A&E target
- Non delivery of BCF target reductions in non-elective activity will lead to fewer resources available for BCF and impact on partnership working with the Local Authority.
- Risk to service delivery as a result of an LCH restructure that impacts on LCH staff supporting Sefton

Overall the CCG is vigilant to the potential risks to the CCG operating licence and maintains a system of strong internal control and risk management. However no organisation can be complacent and the CCG recognises this and has taken steps during the year in a number of key areas to ensure that compliance with the operating licence is maintained and protected.

*Effective governance arrangements* – as highlighted above the CCG keeps under constant review the governance structures and committees that support the Governing body in the discharge of its role and responsibilities

*Performance information* – during the year the integrated performance report which is presented formally to the Governing Body has been subject to regular review, refinement and further strengthening so as to fully meet the needs and requirements of the Governing Body and provide them with assurance as to compliance with the CCG's licence and statutory duties.

## Review of Economy, Efficiency and Effectiveness of the use of Resources

The CCG seeks to gain best value through all of its contracting and procurement processes. The CCG has approved a scheme of delegation, prime financial policies and a schedule of financial limits that ensures there are proper controls in respect of expenditure.

The agreed limits for quotation and tendering are detailed in those policies and staff are required to properly assess bids for services in accordance with the policies.

The CCG buys procurement expertise and support from the Midlands and Lancashire Commissioning Support Unit and this service is delivered by appropriately trained and accredited individuals.

All newly acquired services are subject to robust assessment to ensure that patients are able to benefit from quality, value for money services.

The Governing Body informed by its committees on the economic, efficient and effective use of resources and in particular by the Audit Committee and the Finance and Resources Committee that oversees and directs the use of the CCG resources. In doing so Governing Body members benefit from the experience and skills of a strong and competent senior management team, who work within a strong framework of performance management.

Through the CCG's QIPP Committee programmes of work and service redesign and transformational programmes are all clinically led by Governing Body members who are supported by project leads and a project management infrastructure.

All significant investment decisions are subject to a rigorous assessment and prioritisation process that is applied in such a way as to determine the relative effectiveness of the proposal, including the impact upon key strategic outcomes and objectives. Use is also made of data and support from our public health colleagues in the local authority.

## Review of the Effectiveness of Governance, Risk Management and Internal Control

As accounting officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

### Capacity to Handle Risk

The chief officer has accountability for ensuring there are robust arrangements in place for the identification and management of risk. The chief officer is supported in this role by the chief delivery and integration officer. Expertise and support is also procured from Midlands and Lancashire Commissioning Support Unit (the CSU) who acquired the Cheshire and Merseyside CSU contract following an NHS England transaction, the CSU offer advice to all staff on the identification and management of risk.

The senior management team (SMT) has received training on the development and management of the Governing Body's assurance framework and all staff are able to access "hands on" support at all times. All SMT members have received the risk management strategy and have also had training on incident reporting procedures.

The CCG fosters a culture of openness and encourages the sharing of good practice and learning when things go wrong.

### Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the senior management team, managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The *Governing Body assurance framework* itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, Quality Committee and Finance and Resources Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Governing Body receives the minutes of all committees including the Audit Committee, Quality Committee, Finance and Resources Committee and Service Improvement and Re-design Committee. The Quality Committee approves relevant policies following review and assessment by the Corporate Governance Support Group and the Audit Committee monitors action plans arising from internal audit reviews.

Internal audit is a key component of internal control. The Audit Committee approves the annual internal audit plan, and progress against this plan is reported to each meeting of the committee. The individual reviews carried out throughout the year assist the director of audit to form his opinion, which in turn feeds the assurance process.

Following completion of the planned audit work for the financial year for the clinical commissioning group, the head of internal audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control.

The Head of Internal Audit Opinion concluded:

| ***Significant Assurance**, can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of a particular objective at risk* |
|---|

**Data Quality**

Data services (DSCRO) are commissioned through Arden & GEM CSU who processes and quality assures the data that is received from providers and works with the CCG to challenge providers if inconsistencies are identified.  DSCROs are regional processing centres for The Health and Social Care Information Centre (HSCIC) who are granted powers by the Health and Social Care Act 2012[17] to lawfully process patient identifiable information.

Midlands and Lancashire CSU is commissioned to provide the CCG with *inter alia,* performance reports, contract monitoring reports, quality dashboards and other activity and performance data.

The CCG's BI Team also assesses the quality of the data provided and ensures that concerns are addressed through the provider Information Sub Group meetings.

These processes provide assurances that the quality of the data upon which the membership and Governing Body rely, is robust.

[17] Health and Social Care Act 2012 – Chapter 2 – Health and Social Care Information Centre

The CCG has now completed all of the recommendations from the Internal Audit assessment of significant assurance on Data Quality and Performance Reporting.

**Business Critical Models**

Officers of the CCG have reviewed the Macpherson report to consider the implications for the CCG. The CCG's internal auditors have also undertaken a review of management accounting practices including estimation techniques. Internal Audit reported that are appropriate arrangements in place in respect of the control environment operating in this area.

**Data Security**

We have submitted a level 2 compliance with the information governance toolkit assessment. The CCG's internal auditors (MIAA) provided an assessment of significant assurance on the submission.

NHS South Sefton CCG has put in place policies, procedures, guidance and support to ensure that personal and corporate information is handled legally, securely, efficiently and effectively, in order to deliver high quality services. Performance is monitored through the completion of the annual information governance (IG) toolkit return and reports to the Corporate Governance Group and Quality Committee.

Controls include:

- Mandatory induction and refresher IG training for all staff
- Identifying the movement of personal data and assessing associated risks, and minimising where possible
- Ensuring the encryption of all confidential data stored on portable devices
- Reporting, investigation and escalation of all information governance incidents

**Discharge of Statutory Functions**

The statutory functions of the CCG and the way in which the CCG discharges those duties are explained within the group's constitution that has been approved by NHS England.

In light of the Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

## Conclusion

During the year no significant control issues have been identified. This is confirmed by the Head of Audit opinion and also by the internal audit reviews that have provided the CCG with either a ‘high’ or ‘significant’ assurance on the arrangements in place.

**Fiona Taylor, Accountable Officer, May 2016**

# Remuneration report

The Remuneration Committee membership is made up of five Governing Body Members. It met twice during the year (November 2015, January 2016).

| Name | Title | Membership Period | Attendance at Meetings eligible to attend |
|---|---|---|---|
| **Graham Morris** | Chair and Governing Body Lay Member | All Year | 2/2 |
| **Roger Driver** | Governing Body Lay Member | Until 18 March 2016 | 0/2 |
| **Andy Mimnagh** | Clinical Vice Chair | All Year | 2/2 |
| **Tanya Mulvey** | Practice Manager and Governing Body Member | July till Nov 2015 | 1/1 |
| **Dr Sinha** | GP and Governing Body Member | All Year | 0/2 |

### Policy on remuneration of senior managers

Since the creation of CCGs there has been no mandated guidance on a standardised approach to senior manager remuneration for Clinical Commissioning Groups and as such the CCG continues to use the report commissioned by the Hay Group to provide guidance on the appropriate level of remuneration for Governing Body members and senior executives.

NHS England's Guidance (Remuneration guidance for Chief Officers (where the senior manager also undertakes the accountable officer role) and Chief Finance Officers) continues to be used as a reference for the remuneration of the Chief Officer and Chief Finance Officer roles within the CCG.

Both NHS England and the Hay Group guidance reviewed the pay and employment conditions of other employees in order to determine the framework for senior manager's remuneration. The terms and conditions of service for all NHS staff, except very senior managers (VSMs) are nationally agreed by the NHS Staff Council. These terms and conditions include, pay and allowances; terms of employment such as leave and hours of working; the process for ensuring effective employee relations; and regulations with regard to equality and diversity.

The performance of all senior managers is measured and assessed using our personal development review process which is also extended to all employees throughout the organisation.

### Pensions

NHS staff pensions are covered separately under the NHS rules on superannuation, however, individuals who are employed by the NHS automatically become a member of the NHS Pension Scheme. Membership is voluntary and individuals can currently opt not to join and leave the scheme at any time.

## Policy on senior manager's service contracts

All members of staff, with the exception of the chief finance officer, chief officer and specific Governing Body members, are covered by Agenda for Change contracts of employment with contractual entitlements in line with the national NHS Terms and Conditions of Service as negotiated by the NHS Staff Council.

Contracts for all other roles are compliant with both UK and EU legislation and approved by the CCG's Remuneration Committee. Any future amendments to these contracts or the remuneration associated with them are the responsibility of the Remuneration Committee to review on an annual basis.

## Salaries and allowances

The table below sets out the salaries and allowances we have paid, or that are payable to our senior managers in 2015-2016.

Senior managers are defined in the Government Financial Reporting Manual as 'those persons in senior positions having authority or responsibility for directing or controlling our major activities. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members'.

| Name | Title | Salary & Fees | Taxable Benefits | Annual Performance Related Bonuses | Long Term Performance Related Bonuses | All Pension Related Benefits | Total | Total Prior Year |
|---|---|---|---|---|---|---|---|---|
| | | (bands of £5,000) | (Rounded to the nearest £00) | (bands of £5,000) | (bands of £5,000) | (bands of £2,500) | (bands of £5,000) | (bands of £5,000) |
| **Taylor FL** | Chief Officer | 60 - 65 | 22 | 0 | 0 | 0 - 2.5 | 65 - 70 | 65-70 |
| **McDowell M** | Chief Finance Officer / Deputy Chief Officer | 50 - 55 | 0 | 0 | 0 | 7.5 - 10 | 55 - 60 | 55 - 60 |
| **Fagan DC** | Chief Nurse | 35 - 40 | 0 | 0 | 0 | 10 - 12.5 | 50 - 55 | 50 - 55 |
| **Gillespie C** | Chair & GP Clinical Director | 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 | 15 - 20 |
| **Mimnagh A** | Clinical Vice Chair | 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 | 10 - 15 |
| **Wray J** | GP Clinical Director | 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 | 10 - 15 |
| **Sinha R** | GP Clinical Director | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 | 5 - 10 |
| **Chamberlain PJ** | GP Clinical Director | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 | N/A |
| **Shaw C** | GP Clinical Director | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 | 50 - 55 |

| Name | Title | Salary & Fees | Taxable Benefits | Annual Performance Related Bonuses | Long Term Performance Related Bonuses | All Pension Related Benefits | Total | Total Prior Year |
|---|---|---|---|---|---|---|---|---|
| **Thomas P** | GP Clinical Director | 5 - 10 | 0 | 0 | 0 | 0 | 5 - 10 | 15 - 20 |
| **McDowell D** | Secondary Care Clinician | 20 - 25 | 0 | 0 | 0 | 0 | 20 - 25 | 20 - 25 |
| **Morris GL** | Vice Chair & Lay member - Governance | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 | 10 - 15 |
| **Driver RJ** | Lay Member, Engagement and Patient Experience | 5 - 10 | 0 | 0 | 0 | 0 | 5 - 10 | 5 - 10 |
| **McGibbon S** | Practice Manager | 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 | 0 - 5 |
| **Mulvey T** | Practice Manager | 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 | N/A |

We have a joint management arrangement with neighbouring NHS Southport and Formby CCG. The Chief Officer (Fiona Taylor), Chief Financial Officer (Martin McDowell) and Chief Nurse (Debbie Fagan) receive remuneration for undertaking these roles for both CCGs. Their total banded remuneration from these roles is:

- Fiona Taylor £125,000 to £130,000 and £0 to £2,500 all pension related benefits
- Martin McDowell £100,000 to £105,000 and £7,000 to £10,000 all pension related benefits
- Debbie Fagan £75,000 to £80,000 and £10,000 to £12,500 all pension related benefits

The total remuneration of the chief officer and chief finance officer includes a 20% supplement on their basic salary paid in accordance with NHS England guidance and agreed by our Remuneration Committees to recognise the joint roles that they undertake, as officers covering two CCGs. They hold the same positions with NHS Southport and Formby CCG.

## Pension benefits

| Name | Title | Real increase in pension at age 60 | Real increase in pension lump sum at age 60 | Total accrued pension at age 60 at 31st March 2016 | Lump sum at age 60 related to accrued pension at 31st March 2016 | Cash equivalent transfer value at 1 April 2015 | Cash equivalent transfer value at 1 April 2016 | Real increase in cash equivalent transfer value | Employers contribution to partnership pension |
|---|---|---|---|---|---|---|---|---|---|
| | | (bands of £2,500) | (bands of £2,500) | (bands of £5,000) | (bands of £5,000) | £000 | £000 | £000 | £000 |
| **McDowell M** | Chief Finance Officer / Deputy Chief Officer | 0 - 2.5 | 0 | 25 - 30 | 75 - 80 | 403 | 417 | 15 | 0 |
| **Taylor FL** | Chief Officer | 0 - 2.5 | 2.5 - 5 | 50 - 55 | 160 - 165 | 969 | 997 | 28 | 0 |
| **Fagan DC** | Chief Nurse | 0 - 2.5 | 0 - 2.5 | 25 - 30 | 75 - 80 | 384 | 406 | 22 | 0 |

The information in the table above for our Chief Officer (Fiona Taylor), Chief Finance Officer (Martin McDowell) and Chief Nurse (Debbie Fagan) relates to their total pension benefits arising from their role in South Sefton CCG only.

Certain members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain members.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of the CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for the members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

## Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

## Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

## Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid member of the Governing Body in NHS South Sefton CCG in the financial year 2015-16 was £80,000 to £85,000 (2014-15: £70,000 to £75,000).

This was 3.5 times (2014-15: 3.14) the median remuneration of the workforce, which was £22,940 (2014-15: £22,712).

In 2015-2016, no employees (2014-15: 0) received remuneration in excess of the highest paid member of the Governing Body. Banded Remuneration ranged from £5,000 to £10,000 (2014-15, £5,000 to £10,000) to £80,000 to £85,000 (2014-15, £70,000 to £75,000).

Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions

The pay multiple calculation has been amended to reflect part time employees as full time equivalents. The total pay has also been updated to reflect the overall charge to the organisation rather than the shared cost with NHS Southport & Formby CCG due to the joint management arrangements in place. This is in line with the Manual for Accounts and the prior year calculation has been restated to aid comparison.

## Off payroll engagements

Off payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months are as follows:

| The number that have existed: | Number |
|---|---|
| | |
| • For less than one year at the time of reporting | 0 |
| • For between one and two years at the time of reporting | 0 |
| • For between two and three years at the time of reporting | 0 |
| • For between three and four years at the time of reporting | 0 |
| • For four or more years at the time of reporting | 0 |
| **Total number of existing engagements as of 31 March 2016** | 0 |

All existing off payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

| | Number |
|---|---|
| Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016 | 0 |
| Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations | 0 |
| Number for whom assurance has been requested | 0 |
| Of which, the number: | |
| • For whom assurance has been received | 0 |
| • For whom assurance has not been received | 0 |
| • That have been terminated as a result of assurance not being received | 0 |

| | Number |
|---|---|
| Number of off-payroll engagements of Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year | 0 |
| Number of individuals that have been deemed "Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements) | 15 |

# Staff report

Our staff and members are our greatest asset. To ensure we remain to be an effective and innovative organisation into the future, we must continually support our members and staff to grow and develop their knowledge and skills in line with the latest developments in healthcare and technologies. One of our most important documents is our organisational development plan. We began refreshing the plan in 2015-2016, and its action plan that will be implemented in the year ahead has been informed by our members and staff.

Here are some examples of how we support our membership and workforce:

### Our Governing Body

Our Governing Body participates in monthly development sessions, either alone or with NHS Southport and Formby CCG, which provide an opportunity for reflection on national and local developments to inform our strategy and how it is delivered. Governing Body members have also been able to access a range of personal development opportunities, with some participating in national development programmes or network events with other CCGs.

### Our members

Our member practices are supported to carry out their commissioning responsibilities in a number of different ways.

- Continuing professional development sessions are regularly organised for clinical staff and these are called Protected Learning Time (PLT) events
- Training for wider practice and reception staff around the 'Making Every Contact Count' programme and dedicated, regular PLT sessions focusing on topics such as dementia and learning disabilities
- Our two nurse facilitators plan and support the development and access to education, training and mentoring for practice nurses and healthcare assistants
- We hold quarterly membership meetings where practices come together to discuss wider CCG work
- Supporting practice nurses to prepare for the Nursing and Midwifery Council's updated revalidation process that comes into effect on 1 April 2016. This includes holding a training and education session in December 2015 and providing support for practice nurses to help them in getting ready for the new requirements.
- A weekly e-bulletin provides members with updates on CCG work, along with relevant national publications and development opportunities
- An intranet site provides a wide range of information designed to support our members, which we are continuing to update in 2015-2016 based on member's feedback

## Our staff

At the end of March 2016 we employed 112 people (61 whole time equivalents) to help us carry out our work. This includes commissioning and medicines management professionals, doctors, nurses and a small number of administration and support staff. The majority of our staff work jointly with NHS Southport and Formby CCG through our shared management team arrangements. We also have a small number of joint appointments with Sefton Council.

| | Governing Body | Very Senior Managers | Other employees | Total |
|---|---|---|---|---|
| **Male** | 11 | 0 | 24 | 35 |
| **Female** | 4 | 0 | 73 | 77 |
| **Total** | **15** | **0** | **97** | **112** |

Our staff also continue to access a broad range of development programmes relevant to their roles to assist them in their day to day work:

- We are committed to being a fair and equal employer and our workplace policies are in line with all relevant equality, diversity and human rights legislation to ensure none of our staff are disadvantaged by our working, training or recruiting processes
- We meet regularly to discuss business and performance, and to share ideas and innovation
- We ensure our staff have the resources and development opportunities to help them carry out their day to day work, including support to complete essential core training requirements, holding annual personal development reviews, promoting and providing staff support and occupational health services focusing on health and wellbeing, as well as ensuring easy access to information through our intranet
- We launched a new dedicated monthly e-bulletin in 2015-2016, as a result of staff views gained through a review of our existing communications channels

## Sickness absence rates

Rates of sickness absence in our organisation are low. Our annual rolling sickness absence at the end of March 2016 was 4.01%. We have policies in place that set out how we manage and support staff through periods of illness or other types of leave.

## Disabled employees

We ensure our disabled staff are treated equally, without discrimination and shown due regard. More information can be found on page 30.

## Staff Partnership Forum

We acknowledge that the effective and productive conduct of employee relations benefits significantly from a recognised forum within which all stakeholders play an active role in partnership working. In support of this, we have a recognition agreement with Trade Unions and staff side representatives and actively participate in the Cheshire & Merseyside Staff Partnership Forum which aims to identify and facilitate the workforce and employment aspects of the NHS locally in developing arrangements to implement required changes which may affect the workforce. The Staff Partnership Forum is the main body for actively

engaging, consulting and negotiating with key staff side stakeholders. The forum is authorised to agree, revise and review policies and procedures which may relate to changes in employment legislation and regulation and the terms and conditions of employment affecting our staff covered by the national Agenda for Change Terms and Conditions. Any policies approved by the Staff Partnership Forum during this period were subsequently ratified by the Finance & Resource Committee or Quality Committee which are both sub-committees of the Governing Body.

## INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SOUTH SEFTON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS South Sefton Clinical Commissioning Group (CCG) the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of South Sefton CCG Group, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

### Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2016 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or

- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the above responsibilities.

Certificate

We certify that we have completed the audit of the accounts of NHS South Sefton CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Smith, for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
KPMG LLP (UK)
1 St Peter's Square
Manchester
M2 3AE

26th May 2016

Data entered below will be used throughout the workbook:

| | |
|---|---|
| Entity name: | NHS South Sefton CCG |
| This year | 2015-16 |
| This year ended | 31-March-2016 |
| This year commencing: | 01-April-2015 |

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**Statement of Comprehensive Net Expenditure for the year ended 31-March-2016**

| | Note | **2015-16 £000** | 2014-15 £000 |
|---|---|---|---|
| **Total Income and Expenditure** | | | |
| Employee benefits | 4.1.1 | 3,115 | 2,120 |
| Operating Expenses | 5 | 234,618 | 226,965 |
| Other operating revenue | 2 | (710) | (591) |
| **Net operating expenditure before interest** | | **237,022** | **228,494** |
| Investment Revenue | 8 | 0 | 0 |
| Other (gains)/losses | 9 | 0 | 0 |
| Finance costs | 10 | 0 | 0 |
| **Net operating expenditure for the financial year** | | **237,022** | **228,494** |
| Net (gain)/loss on transfers by absorption | 11 | 0 | 0 |
| **Total Net Expenditure for the year** | | **237,022** | **228,494** |
| Of which: | | | |
| **Administration Income and Expenditure** | | | |
| Employee benefits | 4.1.1 | 2,015 | 1,405 |
| Operating Expenses | 5 | 1,344 | 2,178 |
| Other operating revenue | 2 | (101) | 0 |
| **Net administration costs before interest** | | **3,258** | **3,584** |
| **Programme Income and Expenditure** | | | |
| Employee benefits | 4.1.1 | 1,099 | 715 |
| Operating Expenses | 5 | 233,274 | 224,787 |
| Other operating revenue | 2 | (609) | (591) |
| **Net programme expenditure before interest** | | **233,764** | **224,910** |

| **Other Comprehensive Net Expenditure** | | **2015-16 £000** | 2014-15 £000 |
|---|---|---|---|
| Impairments and reversals | 22 | 0 | 0 |
| Net gain/(loss) on revaluation of property, plant & equipment | | 0 | 0 |
| Net gain/(loss) on revaluation of intangibles | | 0 | 0 |
| Net gain/(loss) on revaluation of financial assets | | 0 | 0 |
| Movements in other reserves | | 0 | 0 |
| Net gain/(loss) on available for sale financial assets | | 0 | 0 |
| Net gain/(loss) on assets held for sale | | 0 | 0 |
| Net actuarial gain/(loss) on pension schemes | | 0 | 0 |
| Share of (profit)/loss of associates and joint ventures | | 0 | 0 |
| Reclassification Adjustments | | | |
| On disposal of available for sale financial assets | | 0 | 0 |
| **Total comprehensive net expenditure for the year** | | **237,022** | **228,494** |

The notes on pages 84 to 125 form part of this statement

**Statement of Financial Position as at 31-March-2016**

| | Note | **2015-16** £000 | 2014-15 £000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 13 | 28 | 43 |
| Intangible assets | 14 | 0 | 0 |
| Investment property | 15 | 0 | 0 |
| Trade and other receivables | 17 | 0 | 0 |
| Other financial assets | 18 | 0 | 0 |
| **Total non-current assets** | | 28 | 43 |
| **Current assets:** | | | |
| Inventories | 16 | 0 | 0 |
| Trade and other receivables | 17 | 1,979 | 1,518 |
| Other financial assets | 18 | 0 | 0 |
| Other current assets | 19 | 0 | 0 |
| Cash and cash equivalents | 20 | 117 | 162 |
| **Total current assets** | | **2,096** | 1,680 |
| Non-current assets held for sale | 21 | 0 | 0 |
| **Total current assets** | | **2,096** | 1,680 |
| **Total assets** | | **2,125** | 1,723 |
| **Current liabilities** | | | |
| Trade and other payables | 23 | (17,143) | (17,568) |
| Other financial liabilities | 24 | 0 | 0 |
| Other liabilities | 25 | 0 | 0 |
| Borrowings | 26 | 0 | 0 |
| Provisions | 30 | (262) | (352) |
| **Total current liabilities** | | **(17,405)** | (17,920) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(15,280)** | (16,197) |
| **Non-current liabilities** | | | |
| Trade and other payables | 23 | 0 | 0 |
| Other financial liabilities | 24 | 0 | 0 |
| Other liabilities | 25 | 0 | 0 |
| Borrowings | 26 | 0 | 0 |
| Provisions | 30 | 0 | (62) |
| **Total non-current liabilities** | | **0** | (62) |
| **Assets less Liabilities** | | **(15,280)** | (16,259) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (15,280) | (16,259) |
| Revaluation reserve | | 0 | 0 |
| Other reserves | | 0 | 0 |
| Charitable Reserves | | 0 | 0 |
| **Total taxpayers' equity:** | | **(15,280)** | (16,259) |

The notes on pages 84 to 125 form part of this statement

The financial statements on pages 80 to 125 were approved by the Governing Body on 25th May 2016 and signed on its behalf

Chief Officer
Fiona Taylor

Chief Finance Officer / Deputy Chief Officer
Martin McDowell

**Statement of Changes In Taxpayers Equity for the year ended 31-March-2016**

| Changes in taxpayers' equity for 2015-16 | General fund £000 | Revaluation reserve £000 | Other reserves £000 | Total reserves £000 |
|---|---|---|---|---|
| **Balance at 1 April 2015** | (16,259) | 0 | 0 | **(16,259)** |
| Transfer between reserves in respect of assets transferred from closed NHS bodies | 0 | 0 | 0 | **0** |
| **Adjusted NHS Clinical Commissioning Group balance at 1 April 2015** | **(16,259)** | **0** | **0** | **(16,259)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16** | | | | |
| Net operating expenditure for the financial year | (237,022) | | | (237,022) |
| Net gain/(loss) on revaluation of property, plant and equipment | | 0 | | 0 |
| Net gain/(loss) on revaluation of intangible assets | | 0 | | 0 |
| Net gain/(loss) on revaluation of financial assets | | 0 | | 0 |
| **Total revaluations against revaluation reserve** | **0** | **0** | **0** | **0** |
| Net gain (loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain (loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain (loss) on pensions | 0 | 0 | 0 | 0 |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea** | **(237,022)** | **0** | **0** | **(237,022)** |
| Net funding | 238,001 | 0 | 0 | 238,001 |
| **Balance at 31 March 2016** | **(15,280)** | **0** | **0** | **(15,280)** |

| Changes in taxpayers' equity for 2014-15 | General fund £000 | Revaluation reserve £000 | Other reserves £000 | Total reserves £000 |
|---|---|---|---|---|
| **Balance at 1 April 2014** | **(16,154)** | **0** | **0** | **(16,154)** |
| Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition | **0** | **0** | **0** | **0** |
| **Adjusted NHS Commissioning Group balance at 1 April 2014** | **(16,154)** | **0** | **0** | **(16,154)** |
| **Changes in NHS Commissioning Group taxpayers' equity for 2014-15** | | | | |
| Net operating costs for the financial year | (228,494) | | | (228,494) |
| Net gain/(loss) on revaluation of property, plant and equipment | | 0 | | 0 |
| Net gain/(loss) on revaluation of intangible assets | | 0 | | 0 |
| Net gain/(loss) on revaluation of financial assets | | 0 | | 0 |
| **Total revaluations against revaluation reserve** | **0** | **0** | **0** | **0** |
| Net gain (loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain (loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain (loss) on pensions | 0 | 0 | 0 | 0 |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised NHS Commissioning Group Expenditure for the Financial Year** | **(228,494)** | **0** | **0** | **(228,494)** |
| Net funding | 228,389 | 0 | 0 | 228,389 |
| **Balance at 31 March 2015** | **(16,259)** | **0** | **0** | **(16,259)** |

The notes on pages 84 to 125 form part of this statement

**NHS South Sefton CCG - Annual Accounts 2015-16**

**Statement of Cash Flows for the year ended 31-March-2016**

| | Note | **2015-16 £000** | 2014-15 £000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (237,022) | (228,494) |
| Depreciation and amortisation | 5 | 15 | 16 |
| Impairments and reversals | 5 | 0 | 0 |
| Movement due to transfer by Modified Absorption | | 0 | 0 |
| Other gains (losses) on foreign exchange | | 0 | 0 |
| Donated assets received credited to revenue but non-cash | | 0 | 0 |
| Government granted assets received credited to revenue but non-cash | | 0 | 0 |
| Interest paid | | 0 | 0 |
| Release of PFI deferred credit | | 0 | 0 |
| Other Gains & Losses | | 0 | 0 |
| Finance Costs | | 0 | 0 |
| Unwinding of Discounts | | 0 | 0 |
| (Increase)/decrease in inventories | | 0 | 0 |
| (Increase)/decrease in trade & other receivables | 17 | (461) | 432 |
| (Increase)/decrease in other current assets | | 0 | 0 |
| Increase/(decrease) in trade & other payables | 23 | (425) | (785) |
| Increase/(decrease) in other current liabilities | | 0 | 0 |
| Provisions utilised | 30 | 0 | 0 |
| Increase/(decrease) in provisions | 30 | (152) | 414 |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(238,046)** | (228,417) |
| | | | |
| **Cash Flows from Investing Activities** | | | |
| Interest received | | 0 | 0 |
| (Payments) for property, plant and equipment | | 0 | 0 |
| (Payments) for intangible assets | | 0 | 0 |
| (Payments) for investments with the Department of Health | | 0 | 0 |
| (Payments) for other financial assets | | 0 | 0 |
| (Payments) for financial assets (LIFT) | | 0 | 0 |
| Proceeds from disposal of assets held for sale: property, plant and equipment | | 0 | 0 |
| Proceeds from disposal of assets held for sale: intangible assets | | 0 | 0 |
| Proceeds from disposal of investments with the Department of Health | | 0 | 0 |
| Proceeds from disposal of other financial assets | | 0 | 0 |
| Proceeds from disposal of financial assets (LIFT) | | 0 | 0 |
| Loans made in respect of LIFT | | 0 | 0 |
| Loans repaid in respect of LIFT | | 0 | 0 |
| Rental revenue | | 0 | 0 |
| **Net Cash Inflow (Outflow) from Investing Activities** | | **0** | 0 |
| | | | |
| **Net Cash Inflow (Outflow) before Financing** | | **(238,046)** | (228,417) |
| | | | |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 238,001 | 228,389 |
| Other loans received | | 0 | 0 |
| Other loans repaid | | 0 | 0 |
| Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT | | 0 | 0 |
| Capital grants and other capital receipts | | 0 | 0 |
| Capital receipts surrendered | | 0 | 0 |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **238,001** | 228,389 |
| | | | |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 20 | **(45)** | (28) |
| | | | |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **162** | 190 |
| | | | |
| Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies | | 0 | 0 |
| | | | |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | | **117** | 162 |

The notes on pages 84 to 125 form part of this statement

**Notes to the financial statements**

## 1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2015-16* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Going Concern

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

### 1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### 1.3 Acquisitions & Discontinued Operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

### 1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

### 1.5 Charitable Funds

From 2014-15, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

### 1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

### 1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

#### 1.7.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Accruals have been included in the financial statements to the extent that the CCG recognises an obligation at the 31 March 2016 for which it had not been invoiced. Estimates of accruals are undertaken by management based on the information available at the end of the financial year, together with past experience.
- Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. Management have made an assessment for the period ended 31 March 2015 these are disclosed at note 30 - Provisions

#### 1.7.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

**Notes to the financial statements**

- Activity is accounted for in the financial year it takes place, and not necessarily when cash payments are made or received. The CCG has a robust process for identifying that activities have taken place and for identifying the appropriate accounting period. Therefore the degree of estimation uncertainty is considered to be low.

**Notes to the financial statements**

1.8 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.9.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.10 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Valuation**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

**Notes to the financial statements**

1.12 **Intangible Assets**

1.12.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 **Measurement**

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 **Donated Assets**

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 **Government Grants**

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

**Notes to the financial statements**

1.17.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 **Private Finance Initiative Transactions**

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 **Services Received**

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.18.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 **PFI Liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 **Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme**

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 **Other Assets Contributed by the Clinical Commissioning Group to the Operator**

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 **Inventories**

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.21 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

## 1.22 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

## 1.23 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

## 1.24 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group contribute annually to a pooled fund, which is used to settle the claims.

## 1.25 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

## 1.26 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

**Notes to the financial statements**

1.27 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.27.1 **Financial Assets at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 **Held to Maturity Assets**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 **Available For Sale Financial Assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.27.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.28.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.28.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.29 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

**Notes to the financial statements**

1.3 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.31 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.32 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries**

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 **Associates**

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 **Joint Ventures**

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 **Joint Operations**

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 **Research & Development**

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.38 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

**2 Other Operating Revenue**

| | 2015-16 Total £000 | 2015-16 Admin £000 | 2015-16 Programme £000 | 2014-15 Total £000 |
|---|---|---|---|---|
| Recoveries in respect of employee benefits | 0 | 0 | 0 | 0 |
| Patient transport services | 0 | 0 | 0 | 0 |
| Prescription fees and charges | 31 | 0 | 31 | 0 |
| Dental fees and charges | 0 | 0 | 0 | 0 |
| Education, training and research | 5 | 1 | 4 | 5 |
| Charitable and other contributions to revenue expenditure: NHS | 0 | 0 | 0 | 0 |
| Charitable and other contributions to revenue expenditure: non-NHS | 61 | 0 | 61 | 0 |
| Receipt of donations for capital acquisitions: NHS Charity | 0 | 0 | 0 | 0 |
| Receipt of Government grants for capital acquisitions | 0 | 0 | 0 | 0 |
| Non-patient care services to other bodies | 590 | 76 | 514 | 586 |
| Continuing Health Care risk pool contributions | 0 | 0 | 0 | 0 |
| Income generation | 0 | 0 | 0 | 0 |
| Rental revenue from finance leases | 0 | 0 | 0 | 0 |
| Rental revenue from operating leases | 0 | 0 | 0 | 0 |
| Other revenue | 23 | 23 | 0 | 0 |
| **Total other operating revenue** | **710** | **101** | **609** | **591** |

The main element of Non-Patient care income in 2015-16 relates to recoveries of healthcare costs for patients residing outside of South Sefton CCG

**3 Revenue**

| | 2015-16 Total £000 | 2015-16 Admin £000 | 2015-16 Programme £000 | 2014-15 Total £000 |
|---|---|---|---|---|
| From rendering of services | 710 | 101 | 609 | 591 |
| From sale of goods | 0 | 0 | 0 | 0 |
| **Total** | **710** | **101** | **609** | **591** |

**4. Employee benefits and staff numbers**

**4.1.1 Employee benefits**

| 2015-16 | Total | | | Admin | | | Programme | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 |
| Employee Benefits | | | | | | | | | |
| Salaries and wages | 2,587 | 2,549 | 38 | 1,681 | 1,636 | 45 | 906 | 913 | (7) |
| Social security costs | 213 | 213 | 0 | 143 | 143 | 0 | 70 | 70 | 0 |
| Employer Contributions to NHS Pension scheme | 315 | 315 | 0 | 192 | 192 | 0 | 123 | 123 | 0 |
| Other pension costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other post-employment benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Gross employee benefits expenditure** | **3,115** | **3,077** | **38** | **2,015** | **1,970** | **45** | **1,099** | **1,107** | **(7)** |
| Less recoveries in respect of employee benefits (note 4.1.2) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total - Net admin employee benefits including capitalised costs** | **3,115** | **3,077** | **38** | **2,015** | **1,970** | **45** | **1,099** | **1,107** | **(7)** |
| Less: Employee costs capitalised | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | **3,115** | **3,077** | **38** | **2,015** | **1,970** | **45** | **1,099** | **1,107** | **(7)** |

**4.1.1 Employee benefits**

| 2014-15 | Total | | | Admin | | | Programme | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 |
| Employee Benefits | | | | | | | | | |
| Salaries and wages | 1,715 | 1,695 | 21 | 1,142 | 1,071 | 71 | 573 | 623 | (50) |
| Social security costs | 160 | 160 | 0 | 108 | 108 | 0 | 52 | 52 | 0 |
| Employer Contributions to NHS Pension scheme | 245 | 245 | 0 | 155 | 155 | 0 | 89 | 89 | 0 |
| Other pension costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other post-employment benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Gross employee benefits expenditure** | **2,120** | **2,099** | **21** | **1,405** | **1,335** | **71** | **715** | **765** | **(50)** |
| Less recoveries in respect of employee benefits (note 4.1.2) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total - Net admin employee benefits including capitalised costs** | **2,120** | **2,099** | **21** | **1,405** | **1,335** | **71** | **715** | **765** | **(50)** |
| Less: Employee costs capitalised | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | **2,120** | **2,099** | **21** | **1,405** | **1,335** | **71** | **715** | **765** | **(50)** |

**4.1.2 Recoveries in respect of employee benefits**

| | 2015-16 | | | 2014-15 |
|---|---|---|---|---|
| | Total £000 | Permanent Employees £000 | Other £000 | Total £000 |
| **Employee Benefits - Revenue** | | | | |
| Salaries and wages | 0 | 0 | 0 | 0 |
| Social security costs | 0 | 0 | 0 | 0 |
| Employer contributions to the NHS Pension Scheme | 0 | 0 | 0 | 0 |
| Other pension costs | 0 | 0 | 0 | 0 |
| Other post-employment benefits | 0 | 0 | 0 | 0 |
| Other employment benefits | 0 | 0 | 0 | 0 |
| Termination benefits | 0 | 0 | 0 | 0 |
| **Total recoveries in respect of employee benefits** | **0** | **0** | **0** | **0** |

4.2 Average number of people employed

| | 2015-16 Total Number | 2015-16 Permanently employed Number | 2015-16 Other Number | 2014-15 Total Number |
|---|---|---|---|---|
| **Total** | **61** | **59** | **2** | 42 |
| Of the above:<br>**Number of whole time equivalent people engaged on capital projects** | **0** | **0** | **0** | 0 |

**4.3 Staff sickness absence and ill health retirements**

| | 2015-16 Number | 2014-15 Number |
|---|---|---|
| Total Days Lost | 597 | 187 |
| Total Staff Years | 77 | 40 |
| **Average working Days Lost** | **8** | **5** |

| | 2015-16 Number | 2014-15 Number |
|---|---|---|
| Number of persons retired early on ill health grounds | 0 | 0 |
| | **£000** | **£000** |
| Total additional Pensions liabilities accrued in the year | 0 | 0 |

*Ill health retirement costs are met by the NHS Pension Scheme*

**4.4 Exit packages agreed in the financial year**

| | 2015-16 Compulsory redundancies | | 2015-16 Other agreed departures | | 2015-16 Total | |
|---|---|---|---|---|---|---|
| | **Number** | **£** | **Number** | **£** | **Number** | **£** |
| Less than £10,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £10,001 to £25,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £25,001 to £50,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £50,001 to £100,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,001 to £200,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| Over £200,001 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** | **0** |

| | 2014-15 Compulsory redundancies | | 2014-15 Other agreed departures | | 2014-15 Total | |
|---|---|---|---|---|---|---|
| | **Number** | **£** | **Number** | **£** | **Number** | **£** |
| Less than £10,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £10,001 to £25,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £25,001 to £50,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £50,001 to £100,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,001 to £200,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| Over £200,001 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** | **0** | **0** |

| | 2015-16 Departures where special payments have been made | | 2014-15 Departures where special payments have been made | |
|---|---|---|---|---|
| | **Number** | **£** | **Number** | **£** |
| Less than £10,000 | 0 | 0 | 0 | 0 |
| £10,001 to £25,000 | 0 | 0 | 0 | 0 |
| £25,001 to £50,000 | 0 | 0 | 0 | 0 |
| £50,001 to £100,000 | 0 | 0 | 0 | 0 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 |
| £150,001 to £200,000 | 0 | 0 | 0 | 0 |
| Over £200,001 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** |

**Analysis of Other Agreed Departures**

| | 2015-16 Other agreed departures | | 2014-15 Other agreed departures | |
|---|---|---|---|---|
| | **Number** | **£** | **Number** | **£** |
| Voluntary redundancies including early retirement contractual costs | 0 | 0 | 0 | 0 |
| Mutually agreed resignations (MARS) contractual costs | 0 | 0 | 0 | 0 |
| Early retirements in the efficiency of the service contractual costs | 0 | 0 | 0 | 0 |
| Contractual payments in lieu of notice | 0 | 0 | 0 | 0 |
| Exit payments following Employment Tribunals or court orders | 0 | 0 | 0 | 0 |
| Non-contractual payments requiring HMT approval* | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** |

**4.5 Pension costs**

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

**4.5.1 Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2015-16, employers' contributions of £315,005 were payable to the NHS Pensions Scheme (2014-15: £244,568) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.1. The employer contribution rate is expected to be reassessed at the actuarial valuation to be carried out as at 31 March 2016.

**5. Operating expenses**

| | 2015-16 Total £000 | 2015-16 Admin £000 | 2015-16 Programme £000 | 2014-15 Total £000 |
|---|---|---|---|---|
| **Gross employee benefits** | | | | |
| Employee benefits excluding governing body members | 2,695 | 1,595 | 1,099 | 1,923 |
| Executive governing body members | 420 | 420 | 0 | 197 |
| **Total gross employee benefits** | **3,115** | **2,015** | **1,099** | **2,120** |
| | | | | |
| **Other costs** | | | | |
| Services from other CCGs and NHS England | 636 | 474 | 162 | 2,813 |
| Services from foundation trusts | 109,939 | 21 | 109,918 | 105,031 |
| Services from other NHS trusts | 60,562 | 0 | 60,562 | 59,632 |
| Services from other NHS bodies | 0 | 0 | 0 | 131 |
| Purchase of healthcare from non-NHS bodies | 26,759 | 0 | 26,759 | 22,400 |
| Chair and Non Executive Members | 0 | 0 | 0 | 179 |
| Supplies and services – clinical | 620 | 0 | 620 | 772 |
| Supplies and services – general | 84 | 178 | (94) | 928 |
| Consultancy services | 77 | 25 | 53 | 65 |
| Establishment | 2,281 | 124 | 2,157 | 2,358 |
| Transport | 0 | 0 | 0 | 0 |
| Premises | 656 | 363 | 293 | 493 |
| Impairments and reversals of receivables | 0 | 0 | 0 | 0 |
| Inventories written down | 0 | 0 | 0 | 0 |
| Depreciation | 15 | 0 | 15 | 16 |
| Amortisation | 0 | 0 | 0 | 0 |
| Impairments and reversals of property, plant and equipment | 0 | 0 | 0 | 0 |
| Impairments and reversals of intangible assets | 0 | 0 | 0 | 0 |
| Impairments and reversals of financial assets | | | | |
| · Assets carried at amortised cost | 0 | 0 | 0 | 0 |
| · Assets carried at cost | 0 | 0 | 0 | 0 |
| · Available for sale financial assets | 0 | 0 | 0 | 0 |
| Impairments and reversals of non-current assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals of investment properties | 0 | 0 | 0 | 0 |
| Audit fees | 54 | 54 | 0 | 0 |
| Other non statutory audit expenditure | | | | |
| · Internal audit services | 32 | 32 | 0 | 32 |
| · Other services | 12 | 12 | 0 | 60 |
| General dental services and personal dental services | 0 | 0 | 0 | 0 |
| Prescribing costs | 29,765 | 0 | 29,765 | 28,758 |
| Pharmaceutical services | 0 | 0 | 0 | 0 |
| General ophthalmic services | 3 | 0 | 3 | 8 |
| GPMS/APMS and PCTMS | 2,284 | 0 | 2,284 | 1,671 |
| Other professional fees excl. audit | 301 | 37 | 264 | 171 |
| Grants to other public bodies | 12 | 0 | 12 | 0 |
| Clinical negligence | 0 | 0 | 0 | 0 |
| Research and development (excluding staff costs) | 0 | 0 | 0 | 0 |
| Education and training | 34 | 24 | 10 | 573 |
| Change in discount rate | 0 | 0 | 0 | 0 |
| Provisions | (152) | 0 | (152) | 414 |
| Funding to group bodies | | 0 | 0 | 0 |
| CHC Risk Pool contributions | 574 | 0 | 574 | 333 |
| Other expenditure | 69 | 0 | 69 | 127 |
| **Total other costs** | **234,618** | **1,344** | **233,274** | **226,965** |
| | | | | |
| **Total operating expenses** | **237,732** | **3,359** | **234,373** | **229,085** |

**6.1 Better Payment Practice Code**

| **Measure of compliance** | **2015-16 Number** | **2015-16 £000** | 2014-15 Number | 2014-15 £000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 7,356 | 33,010 | 5,564 | 23,374 |
| Total Non-NHS Trade Invoices paid within target | 6,737 | 30,558 | 5,039 | 20,854 |
| **Percentage of Non-NHS Trade invoices paid within target** | **91.59%** | **92.57%** | **90.56%** | **89.22%** |
| | | | | |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 1,854 | 175,229 | 1,844 | 171,121 |
| Total NHS Trade Invoices Paid within target | 1,679 | 175,005 | 1,694 | 169,977 |
| **Percentage of NHS Trade Invoices paid within target** | **90.56%** | **99.87%** | **91.87%** | **99.33%** |

| **6.2 The Late Payment of Commercial Debts (Interest) Act 1998** | **2015-16 £000** | 2014-15 £000 |
|---|---|---|
| Amounts included in finance costs from claims made under this legislation | 0 | 0 |
| Compensation paid to cover debt recovery costs under this legislation | 0 | 0 |
| **Total** | **0** | **0** |

**7 Income Generation Activities**

The Clinical Commissioning Group does not undertake and direct income generation activities.

**8. Investment revenue**

The Clinical Commissioning Group does not generate any investment revenue.

**9. Other gains and losses**

The Clinical Commissioning Group has not experienced any other gains or losses.

**10. Finance costs**

The Clinical Commissioning Group has not experienced any other gains or losses.

**11. Net gain/(loss) on transfer by absorption**

The Clinical Commissioning Group has not experienced any gains or losses on absorption transfers.

**12. Operating Leases**

**12.1 As lessee**

**12.1.1 Payments recognised as an Expense**

| | | | | 2015-16 | | | | 2014-15 |
|---|---|---|---|---|---|---|---|---|
| | Land £000 | Buildings £000 | Other £000 | Total £000 | Land £000 | Buildings £000 | Other £000 | Total £000 |
| **Payments recognised as an expense** | | | | | | | | |
| Minimum lease payments | 0 | 549 | 5 | **554** | 0 | 468 | 6 | **473** |
| Contingent rents | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| Sub-lease payments | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| **Total** | **0** | **549** | **5** | **554** | **0** | **468** | **6** | **473** |

Whilst our arrangements with Community Health Partnership's Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements only

**12.1.2 Future minimum lease payments**

| | | | | 2015-16 | | | | 2014-15 |
|---|---|---|---|---|---|---|---|---|
| | Land £000 | Buildings £000 | Other £000 | Total £000 | Land £000 | Buildings £000 | Other £000 | Total £000 |
| **Payable:** | | | | | | | | |
| No later than one year | 0 | 0 | 0 | **0** | 0 | 0 | 6 | **6** |
| Between one and five years | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| After five years | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| **Total** | **0** | **0** | **0** | **0** | **0** | **0** | **6** | **6** |

**12.2 As lessor**
**12.2.1 Rental revenue**

The Clinical Commissioning Group does not have any lease arrangements in this capacity.

**13 Property, plant and equipment**

| 2015-16 | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction and payments on account £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Furniture & fittings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Cost or valuation at 01-April-2015** | 0 | 0 | 0 | 0 | 74 | 0 | 57 | 0 | 131 |
| Addition of assets under construction and payments on account | | | | 0 | | | | | 0 |
| Additions purchased | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions leased | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale and reversals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Upward revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer (to)/from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cumulative depreciation adjustment following revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cost/Valuation At 31-March-2016** | **0** | **0** | **0** | **0** | **74** | **0** | **57** | **0** | **131** |
| **Depreciation 01-April-2015** | 0 | 0 | 0 | 0 | 31 | 0 | 57 | 0 | 88 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassified as held for sale and reversals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals other than by sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Upward revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Charged during the year | 0 | 0 | 0 | 0 | 15 | 0 | 0 | 0 | 15 |
| Transfer (to)/from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cumulative depreciation adjustment following revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Depreciation at 31-March-2016** | **0** | **0** | **0** | **0** | **46** | **0** | **57** | **0** | **103** |
| **Net Book Value at 31-March-2016** | **0** | **0** | **0** | **0** | **28** | **0** | **0** | **0** | **28** |
| Purchased | 0 | 0 | 0 | 0 | 28 | 0 | 0 | 0 | 28 |
| Donated | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Government Granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **0** | **0** | **0** | **28** | **0** | **0** | **0** | **28** |
| **Asset financing:** | | | | | | | | | |
| Owned | 0 | 0 | 0 | 0 | 28 | 0 | 0 | 0 | 28 |
| Held on finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| On-SOFP Lift contracts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PFI residual: interests | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **0** | **0** | **0** | **28** | **0** | **0** | **0** | **28** |

**Revaluation Reserve Balance for Property, Plant & Equipment**

| | Land £000's | Buildings £000's | Dwellings £000's | Assets under construction & payments on account £000's | Plant & machinery £000's | Transport equipment £000's | Information technology £000's | Furniture & fittings £000's | Total £000's |
|---|---|---|---|---|---|---|---|---|---|
| **Balance at 01-April-2015** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation gains | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Release to general fund | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other movements | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **At 31-March-2016** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

**13 Property, plant and equipment cont'd**

**13.1 Additions to assets under construction**

The Clinical Commissioning Group does not hold any assets under construction.

**13.2 Donated assets**

The Clinical Commissioning Group has not received any donated assets.

**13.3 Government granted assets**

The Clinical Commissioning Group has not received any Government granted assets.

**13.4 Property revaluation**

The Clinical Commissioning Group has not been subject to any property revaluations.

13 Property, plant and equipment cont'd

**13.5 Compensation from third parties**

The Clinical Commissioning Group has not received any compensation from third parties.

**13.6 Write downs to recoverable amount**

The Clinical Commissioning Group has not written down any assets to their recoverable amount.

**13.7 Temporarily idle assets**

The Clinical Commissioning Group does not hold any temporary idle assets.

**13.8 Cost or valuation of fully depreciated assets**

**The cost or valuation of fully depreciated assets still in use was as follows:**

| | **2015-16** | 2014-15 |
|---|---|---|
| | **£000** | £000 |
| Land | 0 | 0 |
| Buildings excluding dwellings | 0 | 0 |
| Dwellings | 0 | 0 |
| Plant & machinery | 0 | 0 |
| Transport equipment | 0 | 0 |
| Information technology | 0 | 0 |
| Furniture & fittings | 0 | 0 |
| **Total** | **0** | **0** |

**13.9 Economic lives**

| | **Minimum Life (years)** | **Maximum Life (Years)** |
|---|---|---|
| Buildings excluding dwellings | 0 | 0 |
| Dwellings | 0 | 0 |
| Plant & machinery | 1 | 3 |
| Transport equipment | 0 | 0 |
| Information technology | 0 | 0 |
| Furniture & fittings | 0 | 0 |

**14 Intangible non-current assets**

The Clinical Commissioning Group does not have any intangible non-current assets.

**14 Intangible non-current assets cont'd**

**14.1 Donated assets**

The Clinical Commissioning Group does not hold any donated non-current assets.

**14.2 Government granted assets**

The Clinical Commissioning Group does not hold any Government granted non-current assets.

**14.3 Revaluation**

The Clinical Commissioning Group does not have any intangible non-current assets to revalue.

14 Intangible non-current assets cont'd

**14.4 Compensation from third parties**

The Clinical Commissioning Group has not received any compensation from third parties.

**14.5 Write downs to recoverable amount**

The Clinical Commissioning Group has not written down any items.

**14.6 Non-capitalised assets**

The Clinical Commissioning Group does not hold any significant non-capitalised assets.

**14.7 Temporarily idle assets**

The Clinical Commissioning Group does not hold any temporarily idle assets.

**14.8 Cost or valuation of fully amortised assets**

The Clinical Commissioning Group does not hold significant fully amortised assets.

**15 Investment property**

The Clinical Commissioning Group does not hold any investment properties.

**16 Inventories**

The Clinical Commissioning Group had no inventories as at 31 March 2016.

**17 Trade and other receivables**

| | Current 2015-16 £000 | Non-current 2015-16 £000 | Current 2014-15 £000 | Non-current 2014-15 £000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 848 | 0 | 850 | 0 |
| NHS receivables: Capital | 0 | 0 | 0 | 0 |
| NHS prepayments | 0 | 0 | 0 | 0 |
| NHS accrued income | 570 | 0 | 186 | 0 |
| Non-NHS receivables: Revenue | 431 | 0 | 236 | 0 |
| Non-NHS receivables: Capital | 0 | 0 | 0 | 0 |
| Non-NHS prepayments | 94 | 0 | 219 | 0 |
| Non-NHS accrued income | 11 | 0 | 15 | 0 |
| Provision for the impairment of receivables | 0 | 0 | 0 | 0 |
| VAT | 12 | 0 | 14 | 0 |
| Private finance initiative and other public private partnership arrangement prepayments and accrued income | 0 | 0 | 0 | 0 |
| Interest receivables | 0 | 0 | 0 | 0 |
| Finance lease receivables | 0 | 0 | 0 | 0 |
| Operating lease receivables | 0 | 0 | 0 | 0 |
| Other receivables | 13 | 0 | (2) | 0 |
| **Total Trade & other receivables** | **1,979** | **0** | **1,518** | **0** |
| **Total current and non current** | **1,979** | | **1,518** | |
| Included above: | | | | |
| Prepaid pensions contributions | 0 | | 0 | |

**17.1 Receivables past their due date but not impaired**

| | 2015-16 £000 | 2014-15 £000 |
|---|---|---|
| By up to three months | 304 | 60 |
| By three to six months | 17 | 0 |
| By more than six months | 19 | 47 |
| **Total** | **340** | **107** |

£212k of the amount above has subsequently been recovered post the statement of financial position date.

**17.2 Provision for impairment of receivables**

The Clinical Commissioning Group held no provisions for impairment of receivables at 31 March 2016.

## 18 Other financial assets

### 18.1 Current

| | 2015-16 £000 | 2014-15 £000 |
|---|---|---|
| **Balance at 01-April-2015** | 0 | 0 |
| Additions | 0 | 0 |
| Revaluation | 0 | 0 |
| Impairments | 0 | 0 |
| Impairment reversals | 0 | 0 |
| Transferred from non-current financial assets | 0 | 0 |
| Disposals | 0 | 0 |
| Transfer (to)/from other public sector body | 0 | 0 |
| **At 31-March-2016** | **0** | **0** |

### 18.2 Non-current

| | 2015-16 £000 | 2014-15 £000 |
|---|---|---|
| **Balance at 01-April-2015** | 0 | 0 |
| Additions | 0 | 0 |
| Revaluation | 0 | 0 |
| Impairments | 0 | 0 |
| Impairment reversals | 0 | 0 |
| Transferred from non-current financial assets | 0 | 0 |
| Disposals | 0 | 0 |
| Transfer (to)/from other public sector body | 0 | 0 |
| **At 31-March-2016** | **0** | **0** |

### 18.3 Non-current: capital analysis

| | 2015-16 £000 | 2014-15 £000 |
|---|---|---|
| Capital revenue | 0 | 0 |
| Capital expenditure | 0 | 0 |

## 19 Other current assets

The Clinical Commissioning Group had no other current assets as at 31 March 2016.

**20 Cash and cash equivalents**

| | **2015-16** | 2014-15 |
|---|---|---|
| | **£000** | £000 |
| Balance at 01-April-2015 | 162 | 190 |
| Net change in year | (45) | (28) |
| **Balance at 31-March-2016** | **117** | **162** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 117 | 162 |
| Cash with Commercial banks | 0 | 0 |
| Cash in hand | 0 | 0 |
| Current investments | 0 | 0 |
| **Cash and cash equivalents as in statement of financial position** | **117** | **162** |
| | | |
| Bank overdraft: Government Banking Service | 0 | 0 |
| Bank overdraft: Commercial banks | 0 | 0 |
| **Total bank overdrafts** | **0** | **0** |
| | | |
| **Balance at 31-March-2016** | **117** | **162** |
| | | |
| Patients’ money held by the clinical commissioning group, not included above | 0 | 0 |

**21 Non-current assets held for sale**

The Clinical Commissioning Group held no non-current assets for sale at 31 March 2016.

**22 Analysis of impairments and reversals**

The Clinical Commissioning Group has not incurred any impairments or reversed any impairments in the year to 31 March 2016.

| 23 Trade and other payables | Current 2015-16 £000 | Non-current 2015-16 £000 | Current 2014-15 £000 | Non-current 2014-15 £000 |
|---|---|---|---|---|
| Interest payable | 0 | 0 | 0 | 0 |
| NHS payables: revenue | 1,471 | 0 | 2,441 | 0 |
| NHS payables: capital | 0 | 0 | 0 | 0 |
| NHS accruals | 2,776 | 0 | 2,531 | 0 |
| NHS deferred income | 0 | 0 | 0 | 0 |
| Non-NHS payables: revenue | 1,763 | (0) | 3,423 | 0 |
| Non-NHS payables: capital | 0 | 0 | 0 | 0 |
| Non-NHS accruals | 9,431 | 0 | 7,141 | 0 |
| Non-NHS deferred income | 0 | 0 | 0 | 0 |
| Social security costs | 61 | 0 | 39 | 0 |
| VAT | 0 | 0 | 0 | 0 |
| Tax | 59 | 0 | 31 | 0 |
| Payments received on account | 0 | 0 | 0 | 0 |
| Other payables | 1,581 | 0 | 1,961 | 0 |
| **Total Trade & Other Payables** | **17,143** | **(0)** | **17,568** | **0** |
| Total current and non-current | **17,143** | | **17,568** | |

Other payables include £86k outstanding pension contributions at 31 March 2016

| 24 Other financial liabilities | Current 2015-16 | Non-current 2015-16 | Current 2014-15 | Non-current 2014-15 |
|---|---|---|---|---|
| Embedded derivatives at fair value through the statement | 0 | 0 | 0 | 0 |
| Financial liabilities carried at fair value through profit and | 0 | 0 | 0 | 0 |
| Amortised cost | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** |
| **Total current and non-current** | **0** | | **0** | |

| 25 Other liabilities | Current 2015-16 | Non-current 2015-16 | Current 2014-15 | Non-current 2014-15 |
|---|---|---|---|---|
| Private finance initiative/LIFT deferred credit | 0 | 0 | 0 | 0 |
| Lease incentives | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **0** | **0** |
| **Total current and non-current** | **0** | | **0** | |

**26 Borrowings**

The Clinical Commissioning Group does not have any borrowings at 31 March 2016

## 27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group does not have direct interest in any PFI or LIFT arrangements.

**28 Finance lease obligations**

The Clinical Commissioning Group does not have any finance lease obligations.

**29 Finance lease receivables**

The Clinical Commissioning Group does not have any receivables in respect of finance leases.

**30 Provisions**

| | **Current 2015-16 £000** | **Non-current 2015-16 £000** | Current 2014-15 £000 | Non-current 2014-15 £000 |
|---|---|---|---|---|
| Pensions relating to former directors | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | 0 | 0 | 0 |
| Restructuring | 262 | 0 | 0 | 0 |
| Redundancy | 0 | 0 | 0 | 0 |
| Agenda for change | 0 | 0 | 0 | 0 |
| Equal pay | 0 | 0 | 0 | 0 |
| Legal claims | 0 | 0 | 0 | 0 |
| Continuing care | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 352 | 62 |
| **Total** | **262** | **0** | **352** | **62** |
| | | | | |
| **Total current and non-current** | **262** | | **414** | |

| | **Pensions Relating to Former Directors £000s** | **Pensions Relating to Other Staff £000s** | **Restructuring £000s** | **Redundancy £000s** | **Agenda for Change £000s** | **Equal Pay £000s** | **Legal Claims £000s** | **Continuing Care £000s** | **Other £000s** | **Total £000s** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Balance at 01-April-2015** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **414** | **414** |
| | | | | | | | | | | |
| Arising during the year | 0 | 0 | 262 | 0 | 0 | 0 | 0 | 0 | 0 | 262 |
| Utilised during the year | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversed unused | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (414) | (414) |
| Unwinding of discount | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Change in discount rate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transfer (to) from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance at 31-March-2016** | **0** | **0** | **262** | **0** | **0** | **0** | **0** | **0** | **0** | **262** |
| | | | | | | | | | | |
| **Expected timing of cash flows:** | | | | | | | | | | |
| Within one year | 0 | 0 | 262 | 0 | 0 | 0 | 0 | 0 | 0 | 262 |
| Between one and five years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| After five years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance at 31-March-2016** | **0** | **0** | **262** | **0** | **0** | **0** | **0** | **0** | **0** | **262** |

## 31 Contingencies

### Contingent liabilities

The Clinical Commissioning Group does not have any contingent liabilities.

### Contingent assets

The Clinical Commissioning Group does not have any contingent assets.

**32 Commitments**

**32.1 Capital commitments**

The Clinical Commissioning Group does not have any capital commitments.

**32.2 Other financial commitments**

The Clinical Commissioning Group does not have any other financial commitments.

**33 Financial instruments**

**33.1 Financial risk management**

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

**33.1.1 Currency risk**

The NHS Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

**33.1.2 Interest rate risk**

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

**33.1.3 Credit risk**

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

**33.1.3 Liquidity risk**

The NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

**33 Financial instruments cont'd**

**33.2 Financial assets**

| | **At 'fair value through profit and loss' 2015-16 £000** | **Loans and Receivables 2015-16 £000** | **Available for Sale 2015-16 £000** | **Total 2015-16 £000** |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | 0 |
| Receivables: | | | | |
| · NHS | 0 | 1,418 | 0 | 1,418 |
| · Non-NHS | 0 | 442 | 0 | 442 |
| Cash at bank and in hand | 0 | 117 | 0 | 117 |
| Other financial assets | 0 | 13 | 0 | 13 |
| **Total at 31-March-2016** | **0** | **1,990** | **0** | **1,990** |

| | At 'fair value through profit and loss' 2014-15 £000 | Loans and Receivables 2014-15 £000 | Available for Sale 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | 0 |
| Receivables: | | | | |
| · NHS | 0 | 850 | 0 | 850 |
| · Non-NHS | 0 | 236 | 0 | 236 |
| Cash at bank and in hand | 0 | 162 | 0 | 162 |
| Other financial assets | 0 | (2) | 0 | (2) |
| **Total at 31-March-2016** | **0** | **1,247** | **0** | **1,247** |

**33.3 Financial liabilities**

| | **At 'fair value through profit and loss' 2015-16 £000** | **Other 2015-16 £000** | **Total 2015-16 £000** |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 4,247 | 4,247 |
| · Non-NHS | 0 | 12,775 | 12,775 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **17,022** | **17,022** |

| | At 'fair value through profit and loss' 2014-15 £000 | Other 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 4,973 | 4,973 |
| · Non-NHS | 0 | 12,525 | 12,525 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31-March-2016** | **0** | **17,498** | **17,498** |

**34 Operating segments**

| | Gross expenditure £'000 | Income £'000 | Net expenditure £'000 | Total assets £'000 | Total liabilities £'000 | Net assets £'000 |
|---|---|---|---|---|---|---|
| Commissioning of Healthcare Services | 237,732 | (710) | **237,022** | 2,125 | (17,405) | **(15,280)** |
| | 0 | 0 | **0** | 0 | 0 | **0** |
| **Total** | **237,732** | **(710)** | **237,022** | **2,125** | **(17,405)** | **(15,280)** |

# Reconciliation between Operating Segments and SoCNE

| | 31-Mar-16 £'000 |
|---|---|
| Total net expenditure reported for operating segments | 237,022 |
| Reconciling items: | 0 |
| Total net expenditure per the Statement of Comprehensive Net Expenditure | 237,022 |

# Reconciliation between Operating Segments and SoFP

| | 31-Mar-16 £'000 |
|---|---|
| Total assets reported for operating segments | 2,125 |
| Reconciling items: | 0 |
| **Total assets per Statement of Financial Position** | **2,125** |

| | 31-Mar-16 £'000 |
|---|---|
| Total liabilities reported for operating segments | (17,405) |
| Reconciling items: | 0 |
| Total liabilities per Statement of Financial Position | **(17,405)** |

**35 Pooled budgets**

The NHS Clinical Commissioning Group share of the income and expenditure handled by the pooled budget in relation to the Better Care Fund in the financial year were:

| | **2015-16** | 2014-15 |
|---|---|---|
| | **£000** | £000 |
| Income | 11,840 | 0 |
| Expenditure | 11,840 | 0 |

The Better Care Fund (BCF) came into operation on 1 April 2015, with £3.46 billion of NHS England's funding to CCGs ring-fenced for the establishment of the fund. To administer the fund, CCGs were required to establish joint arrangements with local authorities to operate a pooled budget to deliver more integrated health and social care.

Southport & Formby CCG is party to a Better Care Fund pooled budget arrangement with South Sefton CCG and Sefton Metropolitan Borough Council – the total fund value is £24.231m, Southport & Formby CCG's share of this fund is £11.840m. The Better Care Fund arrangement encompasses three key themes:

- Self-Care, Wellbeing and Prevention
- Integrated Care at locality level building on Virtual Ward and Care Closer to Home Initiatives
- Intermediate Care and Re-ablement

The income and expenditure detailed in the table above, is analysed within note 5 Operating Expenses

**36 NHS Lift investments**

The Clinical Commissioning Group does not hold any LIFT investments at 31 March 2016.

**37 Related party transactions**

**Details of related party transactions with individuals are as follows:**

| | | Payments to Related Party £000 | Receipts from Related Party £000 | Amounts owed to Related Party £000 | Amounts due from Related Party £000 |
|---|---|---|---|---|---|
| **Dr Clive Shaw** | | | | | |
| | SHAW & MCDONAGH | 88 | - | 5 | - |
| | DR CLIVE SHAW | 1 | - | - | - |
| **Dr Craig Gillespie** | | | | | |
| | THE BLUNDELLSANDS SURGERY | 255 | - | - | - |
| | DR CRAIG GILLESPIE | - | - | - | - |
| | TONG & GILLESPIE | 27 | - | - | - |
| **Dr Paul Thomas** | | | | | |
| | THOMAS B & PJ | 6 | - | - | - |
| | HIGH PASTURES SURGERY | 204 | - | 13 | - |
| | THOMSON & PARTNERS | 49 | - | - | - |
| **Dr John Wray** | | | | | |
| | WRAY & PARTNERS | 4 | - | - | - |
| | WESTWAY MEDICAL CENTRE | 168 | - | 3 | - |
| **Dr Ricky Sinha** | | | | | |
| | DR RK SINHA | 5 | - | - | - |
| | NORTH PARK MEDICAL CENTRE | 98 | - | - | - |
| **Tanya Mulvey** | | | | | |
| | STRAND MEDICAL CENTRE | 160 | - | - | - |
| **Sharon McGibbon** | | | | | |
| | HUGHES & PARTNERS | 110 | - | - | - |
| **Dr Andy Mimnagh** | | | | | |
| | HUGHES & PARTNERS | 110 | - | - | - |
| **Lin Bennett** | | | | | |
| | FORD MEDICAL PRACTICE | 107 | - | - | - |
| | WILLIAMS & PARTNERS | 10 | - | - | - |
| **Dr Nigel Tong** | | | | | |
| | TONG & GILLESPIE | 27 | - | - | - |
| | THE BLUNDELLSANDS SURGERY | 255 | - | - | - |
| **James Creese** | | | | | |
| | STEPHENSON & PARTNERS | 103 | - | 6 | - |
| **Jayne Byrne** | | | | | |
| | MARIE CURIE | 9 | - | 1 | - |

The Clinical Commissioning Group have a joint management arrangement with neighbouring NHS Southport & Formby CCG. The Chief Officer (Fiona Taylor), Chief Finance Officer (Martin McDowell) and Chief Nurse (Debbie Fagan) receive remuneration for undertaking these roles for both CCGs.

The transactions listed above are payments made to organisations with which the Governing Body member or employee quoted has a connection, and has declared an interest. They are not payments made directly to the individuals concerned unless quoted otherwise.

The majority of the related party payments listed above relate to locally enhanced services that the CCG assumed responsibility for with effect from 1st April 2013 which are paid to all participating practices in the CCG.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent. For example:

• NHS England
• NHS Foundation Trusts
• NHS Trusts
• NHS Litigation Authority; and,
• NHS Business Services Authority.

In addition the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Sefton Metropolitan Borough Council.

**38 Events after the end of the reporting period**

There are no post balance sheet events which have taken place which will have a material effect on the financial statements of the Clincal Commissioning Group.

**39 Losses and special payments**

The Clinical Commissioning Group has not incurred any losses or special payments in the year to 31 March 2016.

**40 Third party assets**

The Clinical Commissioning Group held no assets on behalf of other parties during the year to 31 March 2016.

**41 Financial performance targets**

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS South Sefton Clinical Commissioning Group's performance against those duties was as follows:

| | **2015-16 Target** | **2015-16 Performance** | 2014-15 Target | 2014-15 Performance |
|---|---|---|---|---|
| Expenditure not to exceed income | £240.1m | £237.7m | £235.3m | £232.1m |
| Capital resource use does not exceed the amount specified in Directions | 0 | 0 | 0 | 0 |
| Revenue resource use does not exceed the amount specified in Directions | £239.4m | £237.0m | £231.3m | £228.5m |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0 | 0 | 0 |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0 | 0 | 0 |
| Revenue administration resource use does not exceed the amount specified in Directions | £3.296m | £3.258m | £4.058m | £3.584m |

**42 Impact of IFRS**

| | **2015-16 £'000** | 2014-15 £'000 |
|---|---|---|
| Depreciation charges | 0 | 0 |
| Interest expense | 0 | 0 |
| Impairment charge: Annually Managed Expenditure | 0 | 0 |
| Impairment charge: Departmental Expenditure Limit | 0 | 0 |
| Other Expenditure | 0 | 0 |
| Revenue receivable from subleasing | 0 | 0 |
| **Total IFRS Expenditure (IFRIC 12)** | **0** | **0** |
| Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue) | 0 | 0 |
| **Net IFRS Change (IFRIC 12)** | **0** | **0** |
| Capital Consequences of IFRS: private finance initiative/LIFT and other service concession arrangements under IFRIC 12 | | |
| Capital expenditure 2014-15 | 0 | 0 |
| UK GAAP capital expenditure 2014-15 (reversionary interest) | 0 | 0 |

**43 Analysis of charitable reserves**

The Clinical Commissioning Group does not hold any charitable reserves at 31 March 2016.

## NHS South Sefton CCG

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**On request this report can be provided in different formats, such as large print, audio or Braille versions and in other languages.**